

Paula K. Lundberg-Love, Kevin L. Nadal, and
Michele A. Paludi, Editors

WOMEN AND MENTAL DISORDERS

VOLUME ONE:

*Understanding Women's
Unique Life Experiences*



Women and Mental Disorders

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Women and Mental Disorders

Volume I

Understanding Women's Unique Life Experiences

**Paula K. Lundberg-Love, Kevin L. Nadal,
and Michele A. Paludi, Editors**

Foreword by Ellen Cole

Women's Psychology
Michele A. Paludi, Series Editor



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I dedicate this book set to all of the women who have struggled to resolve the myriad psychological challenges that we all have encountered during the course of our lives, to the women who not only survived those experiences but thrived in spite of them and thereby created a better human existence. And to all of the women who have given me the opportunity to accompany them on their powerful therapeutic journeys, these volumes are both of you and for you.

Paula K. Lundberg-Love

I dedicate this book set to the fierce and fabulous women who have made my life complete: my mother, my lolas, my aunties, my cousins, my teachers, my mentors, my students, and my dear friends. I also dedicate this book to women everywhere. May their spirits, passion, and love continue to make the world go around.

Kevin L. Nadal

I dedicate this book set to older women who were silenced and labeled as crazy during their lifetimes and to younger women to encourage them to continue to challenge the mental health establishment in honor of their foremothers.

Michele A. Paludi

The criterion of mental health is not one of an individual adjustment to a given social order, but a universal one, valid for all ..., of giving a satisfactory answer to the problem of human existence.

Erich Fromm

Adult women, all of us, have to come to grips with how we have been affected by gender norms, and how we have been silenced. We have to help our daughters. Understanding it within ourselves and helping our young girls stand up for themselves is one way.

Jane Fonda

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Series Foreword

Michele A. Paludi

Because women's work is never done and is underpaid or unpaid or boring or repetitious and we're the first to get fired and what we look like is more important than what we do and if we get raped it's our fault and if we get beaten we must have provoked it and if we raise our voices we're nagging bitches and if we enjoy sex we're nymphos and if we don't we're frigid and if we love women it's because we can't get a "real" man and if we ask our doctor too many questions we're neurotic and/or pushy and if we expect childcare we're selfish and if we stand up for our rights we're aggressive and "unfeminine" and if we don't we're typical weak females and if we want to get married we're out to trap a man and if we don't we're unnatural and because we still can't get an adequate safe contraceptive but men can walk on the moon and if we can't cope or don't want a pregnancy we're made to feel guilty about abortion and . . . for lots of other reasons we are part of the women's liberation movement.

Author unknown, quoted in *The Torch*,
September 14, 1987

This sentiment underlies the major goals of Praeger's book series *Women's Psychology*:

1. *Valuing women.* The books in this series value women by valuing children and working for affordable child care; valuing women by respecting all physiques, not just placing value on slender women; valuing women by acknowledging older women's wisdom, beauty, and aging; valuing women who have been

- sexually victimized and viewing them as survivors; valuing women who work inside and outside of the home; and valuing women by respecting their choices of careers, whom they mentor, reproductive rights, spirituality, and sexuality.
2. *Treating women as the norm.* The books in this series make up for women's issues typically being omitted, trivialized, or dismissed from other books on psychology.
 3. *Taking a non-Eurocentric view of women's experiences.* The books in this series integrate the scholarship on race and ethnicity into women's psychology, thus providing a psychology of *all* women. Women typically have been described collectively, but we are diverse.
 4. *Facilitating connections between readers' experiences and psychological theories and empirical research.* The books in this series offer readers opportunities to challenge their views about women, feminism, sexual victimization, gender role socialization, education, and equal rights. These texts thus encourage women readers to value themselves and others. The accounts of women's experiences as reflected through research and personal stories in the texts in this series have been included for readers to derive strength from the efforts of others who have worked for social change on the interpersonal, organizational, and societal levels.

A student in one of my courses on the psychology of women once stated:

I learned so much about women. Women face many issues: discrimination, sexism, prejudices ... by society. Women need to work together to change how society views us. I learned so much and talked about much of the issues brought up in class to my friends and family. My attitudes have changed toward a lot of things. I got to look at myself, my life, and what I see for the future. (Paludi, 2002)

It is my hope that readers of the books in this series will also reflect on the topics and look at themselves, their own lives, and what they see for the future.

The four-volume set *Women and Mental Disorders* provides readers with the opportunity to accomplish this goal and offers suggestions for psychotherapists, career counselors, academicians, attorneys, and health professionals who work with women. This set also assists us as advocates in guiding institutional and social policy change in work and educational institutions and in lobbying state and federal legislators on issues related to women and mental health, especially violence against women.

REFERENCE

Paludi, M. (2002). *The psychology of women* (2nd ed.). Upper Saddle River, NJ: Prentice Hall.

Foreword

Ellen Cole

Many of the readers of this four-volume book set will be too young to recall that it was Carol Hanisch, a radical feminist from New York City, who popularized the phrase “the personal is political” in a 1969 essay with the same title. I am reminded of that phrase today and its offshoot, “the political is personal,” as I sit here to write this foreword on March 9, 2011, sandwiched between a day that is political yet personal and a day that is personal yet political. You see, yesterday we celebrated the 100th anniversary of International Women’s Day. Tomorrow, March 10, I turn 70.

The first International Women’s Day was held in 1911 in Germany, Austria, Denmark, and Switzerland. Today it is a worldwide annual event that continues to honor women’s achievements, educate about the importance and worth of women in society, and raise awareness of both gains made and injustices, atrocities, and violence against women still to be overcome.

Clearly, many gains have been made since 1911. Economic opportunities, political participation, and educational attainment for women are vastly improved. And yet recent headlines scream at us that our work is far from done. A recent White House report, for example, states that men still get paid more to do the same jobs as women (in 2009 women made on average 75% of what their male counterparts earned), and women are more likely than men to live in poverty. Sex trafficking is called the new slavery. We read reports about women in Afghanistan who are set on fire or who set themselves on fire to escape impossible lives or about women being held in U.S. custody, awaiting trial or deportation, who are sexually assaulted by male guards. The list is long. The political is personal.

Tomorrow I turn 70. I have lived through the second wave of feminism and its many offspring. I’ve seen the development of women’s studies and gender studies

as respected academic disciplines and the development of feminist psychology and feminist therapy. I've seen the movement embrace and then be led by women of color and lesbian, bisexual, and transgender women. I've seen new foci emerge and become front and center in feminist scholarship: multiculturalism and diversity, social justice and social action, and feminist collaboration, process, and leadership, to name a few. I feel incredibly fortunate to have been able to participate in what may be the revolution of the century, that of the rights of women and girls. But it is a revolution that is far from complete. The personal is political.

I want to commend the editors and the authors of this four-volume book set. They tackle it all (I say this with forethought), stating their major goals as valuing women, treating women as the norm, coming from a non-Eurocentric perspective, and connecting theory, research, and women's experience. The author list reads like a who's who in women's mental health and feminist psychology. The topics are current and far-ranging. If you would like to know more about women with disabilities, the feminization of poverty, psychological well-being for women, microaggressions against women, women and spirituality, reproduction, hate crimes, intimate partner abuse, specific disorders (e.g., agoraphobia, eating disorders, borderline personality disorder, sexual dysfunction, teenage cutting), or a variety of approaches to treatment and research, you will find it and much more in the pages of these four volumes. It is exhilarating to know that they are available as resources for all of us in education, health, social policy, and more who work with women. I am grateful to the editors and authors for the timeliness of this contribution. Two days ago, Secretary of State Hillary Rodham Clinton told a *Newsweek* reporter that "I believe that the rights of women and girls is the unfinished business of the 21st century." I agree, and the chapters in this book set help us move toward finishing that business.

Acknowledgments

Editing these volumes with Michele Paludi and Kevin Nadal has been an enriching experience, and I hope it is the first of many. Having the support and dedication of Debbie Caravalko at Praeger as a mentor is always a rewarding endeavor. The wide range of expertise of all of the contributors made this project a stimulating and enriching one. I also want to acknowledge three people who have supported me in this project in spite of obstacles encountered by them, namely my colleague Andrew Schmitt and my accomplished graduate students Wes Parks and Desiree Glaze. Thank you for your commitment and your dedication.

Also noteworthy are the people who serve as my inspiration when I engage in an endeavor such as this. They are my wonderful daughter Jill Wright and my two irrepressible granddaughters, Lexi and Lily Wright. I hope that books such as this one inspire them.

However, the person who has probably supported me the most in my scholarly endeavors and believed in me since our journey through graduate school is my friend Michele Paludi. Thank you Michele for all of the enrichment that you have generously provided to so many women.

Paula K. Lundberg-Love

I thank Michele Paludi and Paula Lundberg-Love for giving me the opportunity to edit this book set. I am looking forward to a future of collaborative efforts. I thank my family and friends, who have always been supportive of my career and my passion for social justice. I especially thank my parents, my brothers, my sister; the Yabut, Nadal, and Tamayo clans; and Randy Fabellore. And finally, I thank all of the contributors for their expertise and fervor. We

need more people like you to advocate for the marginalized and to give voice to those who are silenced.

Kevin L. Nadal

I thank Paula Lundberg-Love and Kevin Nadal for the opportunity to collaborate with them on this book set. Our collaboration has been a wonderful experience for me. I also acknowledge the support and caring from the following people during the preparation of this book set: Rosalie Paludi, Lucille Paludi, Carmen Paludi Jr., Cay Raycroft, and David Raycroft. Working with Debbie Carvalko at Praeger again has been rewarding. I thank her for her encouragement, mentoring, and support.

I also have learned a great deal from the contributors to this book set. Thank you for being part of this project. Your work has strengthened our understanding of women and mental disorders.

Michele A. Paludi

Introduction

Michele A. Paludi, Paula K. Lundberg-Love,
and Kevin L. Nadal

CLAUDIA: NUTS?

The ethic of mental health is masculine in our culture. This double standard of sexual mental health, which exists side by side with a single and masculine standard of *human* mental health, is enforced by both society and clinicians. Although the limited “ego resources,” and unlimited “dependence,” and fearfulness of most women is pitied, disliked, and “diagnosed,” by society and its agent-clinicians, any other kind of behavior is unacceptable in women!

Phyllis Chesler (*Women and Madness*, 1972, p. 69)

In *Nuts*, Tom Topor’s play that was later adapted to the screen (starring Barbra Streisand and directed by Martin Ritt), the protagonist, Claudia Draper, is confined to a mental hospital by her parents in an effort to keep her from standing trial for the murder of a client. The play and movie depict Claudia, a high-class escort, in court fighting for her right to stand trial for manslaughter rather than being declared mentally incompetent. Kempley (1987, p. 3) stated that *Nuts* has the purpose of “pitting inner truths against outward appearances to force us to decide who is and is not nuts.”

During the competency hearing, Claudia states that “I am not just a picture in your heads. I am not just a daughter, or a wife, or a hooker, or a patient or a defendant.” She is determined that others not label her or control her life according to their terms, to their perceptions of who they think she is. She speaks up against psychiatrists who don’t like her and challenge their authority.

Claudia keeps maintaining that she is sane. As Brussat and Brussat (1987, p. 2) stated, “*Nuts* is a gutsy movie ... with an unlikable heroine who refuses to submit to the purposes, fantasies, or needs of others.” The viewer comes to learn that Claudia was sexually molested by her stepfather for years until she was 16 years old. We further learn that she killed her client in self-defense.

DORA/IDA: MENTALLY ILL?

The great question that has never been answered and which I have not yet been able to answer, despite my thirty years of research into the feminine soul, is “What does a woman want?”

Sigmund Freud

Nuts in many ways is a retelling of a classic case discussed by Sigmund Freud in his 1905 article “Fragment of an Analysis of a Case of Hysteria.” This “case of hysteria” is better known in academic and lay circles as the case of “Dora.” Dora (not her real name) was an 18-year-old woman who was brought for treatment to Freud by her father, one of Freud’s former patients. Dora’s parents were concerned about her based on some recent behavior, including a suicide note. Freud also noted that Dora had a “nervous” cough, a history of fainting spells, headaches, and depression that dated back to her childhood. Dora’s “most troubling symptom” for Freud was her “complete loss of voice.” Freud diagnosed Dora as a “typical case of hysteria.” His goal was to explain to her the sexual meanings of her symptoms: repressed content of her early sexuality, masturbatory fantasies, lesbian fantasies, and incestuous desires for her father.

Freud learned that Dora’s father was having an extramarital affair with Frau K., the wife of a family friend, Herr K. Herr K. had attempted to rape Dora, the first time when she was 14 years old. Dora explained that she believed “she had been handed over to Herr K.” by her father in exchange for Herr K.’s complicity in the affair. Dora also believed that her father “handed her over” to Freud because he feared that she would discuss the affair. Her father hired Freud to “bring her to reason” (Freud, 1905, pp. 188, 183).

Initially Freud believed Dora’s account of why her father had brought her to him for treatment: “I came to the conclusion that Dora’s story must correspond to the facts in every respect.” Freud noted that Dora’s father and Herr K. conspired against her: “Each of the two men avoided drawing any conclusions from the other’s behavior which would have been awkward for his own plans” (Freud, 1905, p. 35).

We note, however, that Freud published the case, despite the fact it was incomplete, because he believed that it demonstrated the sexual origins of hysteria. In a critique of Freud’s analysis, Showalter (1985, p. 160) noted:

In his case history of Dora, if not in the actual treatment, Freud is determined to have the last word—he even has a postscript—in constructing his own “intelligible, consistent, and unbroken” account of her hysteria.

He asserts his intellectual superiority to this bright but rebellious young woman. He uses his text to demonstrate his power to bring a woman to reason, and to bring reason to the mysteries of woman.

Similar to what we learn by watching *Nuts*, there is an alternative analysis to Dora's behavior. She was brought to Freud by her father to cast her in a sick role. She was sexually abused by a trusted family friend when she was a young adolescent. And her experiences were relabeled by Freud in order to support his theory of female personality development.

Claudia's parents wanted her committed to a mental hospital because she must be nuts to kill a man and not discuss the sexual abuse by her stepfather that she endured for years (her mother stated that she was unaware of the abuse). Claudia's therapists reinterpreted all of her comments and nonverbal behavior in terms of pathology. Like Dora, Claudia was caught in a web of deceit and betrayal. Also similar to Claudia, Dora's name was changed by Freud. Her real name was Ida Bauer. Claudia kept being referred to by the wrong name, a name given to her in the hearing trial. Williams (1983, p. 42) noted that Freud might have said to Ida, "You are right and they are wrong." Freud did not, however, and Ida continued to have symptoms throughout her adult life.

Cixous (1976) interpreted the case of Dora/Ida in terms of the silencing of women who question patriarchal assumptions. According to Cixous, "Silence is the mark of hysteria. The great hysterics have lost speech ... their tongues are cut off and what talks isn't heard because it's the body that talks and man doesn't hear the body" (p. 49). Showalter (1985, p. 161) also recognized that women's hysteria fits in well with patriarchy: "Hysteria is tolerated because in fact it has no power to effect cultural change; it is much safer for the patriarchal order to encourage and allow discontented women to express their wrongs through psychosomatic illness than to have them agitating for economic and legal rights."

Thus, women who behave according to social expectations were often considered crazy. As Chesler (1972) noted, being too "feminine" or not "feminine" enough were grounds for being considered mentally ill.

WOMEN: UNHEALTHY ADULTS? THE DOUBLE STANDARD FOR MENTAL HEALTH

As a feminist therapist, I had had ample opportunity to observe the negative synergy of trauma and silence, abuse and secrecy, that would lead women to feel and act crazy, when in fact it was mainly the context in which they were forced to operate that was pathological.

Laura S. Brown

That there exists a double standard for mental health was demonstrated by Broverman, Broverman, Clarkson, Rosenkrantz, and Vogel (1970), who

found that mental health practitioners described characteristics of adult men and adults in a similar manner but differed from the characteristics that they assigned to adult women. Adults and adult men were described by personality characteristics as follows: very direct, very logical, can make decisions easily, and never cry. Adult women were described with the following characteristics: less independent, very illogical, very sneaky, less adventurous, more easily influenced, and very excitable in minor crises. This research suggested that a woman could not be simultaneously described as a healthy woman and a healthy adult. According to Broverman et al., “The general standard of health is actually applied only to men, while healthy women are perceived as significantly less healthy by adult standards” (p. 5).

Women’s psychological adjustment has been constructed based on male development. Consequently, feminist theorists and therapists have developed new models of mental health that value women and women’s roles (Gilbert, 1999; Russo & Tartaro, 2008; Landrine & Russo, 2009). There have been five priority areas outlined to meet this goal of valuing women in mental health research and treatment (e.g., Eichler & Parron, 1987):

1. Diagnosis and treatment of mental disorders in women.
2. Stressors involved in poverty.
3. Stressors involved in multiple roles of partner, parent, elder caregiver, and employee.
4. Older women’s mental health issues.
5. Causes and mental health impact of violence against women.

Each of these priority areas will be briefly addressed below. These areas are also addressed in the four volumes of this book set.

Diagnosis and Treatment of Mental Disorders in Women

Women are diagnosed and treated for mental illness at a higher rate than men (Russo & Tartaro, 2008). Women are more likely than men to be diagnosed as being agoraphobic, having anxiety, being depressed, or having an eating disorder (Desjarlais, Eisenberg, Good, & Kleinman, 1996; Sachs-Ericsson & Ciarlo, 2000). Comorbidity is also higher for women. Women are more likely to have three or more psychiatric disorders in their life cycle (Russo & Tartaro, 2008). Furthermore, according to Russo and Tartaro (2008, p. 449), “Evidence for overpathologizing by psychologists has been in higher probability of overdiagnosis of depression (particularly by male psychiatrists) in women.” In addition to overpathologizing mental disorders in women, some disorders such as alcoholism and drug abuse have been underdiagnosed in women (Russo, 1995).

Research has also highlighted the fact that women (especially older women) are more likely than men to be prescribed psychotropic drugs at higher rates

(Hamilton, Grant, & Jensvold, 1996). Yonkers and Hamilton (1995) pointed out that therapists misdiagnose women as being depressed when they may have other disorders that are being relabeled as depression.

Several studies have interpreted the diagnostic labeling as resulting from one of two explanations: (1) women are more likely to exhibit behaviors that men will label as mental illness because women have been socialized to express their emotions or (2) women have unequal social position and experience more discrimination, harassment, and other forms of violence and victimization (Gilbert, 1999; Paludi & Denmark, 2011).

Furthermore, women from different cultures and with varying sexual orientations and gender identities are often misdiagnosed because their social identities do not match that of the majority culture. Thus, it is even more important to recognize how intersectional identities may result in misdiagnoses.

Stressors Involved in Poverty

Women's depressive symptomatology has been explained in part by low-income and ethnic minority or racial minority status (Belle, 1984). Belle, Longfellow, Makosky, Saunders, and Zerkowitz (1981) reported that their sample of 42 urban low-income mothers had personally experienced 37 violent events and witnessed 35 stressful events to friends and family during the previous two years. In addition, Brown (1995) noted that living in dangerous neighborhoods, having financial concerns, and living in inadequate housing are more significant stressors for women than are acute crises. Herd (2009) found that older women are more likely to be living in poverty, noting marriage and public pension benefits as contributing factors to the poverty.

The phrase "feminization of poverty" (Pearce, 1978) refers to more women heads of households who are living below the poverty line. Their experiences result from nonpayment of child support following a divorce and inadequate and/or expensive child care (Gadalla, 2008). Belle (1984) also found that poverty undermines the sources of social support for women that otherwise buffer the impact of stress. Because women are also experiencing stress in their support system, their lives have more stress, and they are therefore at greater risk for depression. White (2010) reported that poverty for women makes them vulnerable to HIV transmission.

Polakoff and Gregory (2002), Fukuda-Parr (1999), and Thibos, Lavin-Loucks, and Martin (2007) noted that the feminization of poverty includes much more than financial need. According to Thibos et al., "being poor also implies the absence of choice, the denial of opportunity, the inability to achieve life goals, and ultimately the loss of hope. Thus, the phenomenon of a feminized poverty extends beyond the economic domains of income and material needs to the core of individual and family life. ... Indeed, some of the most striking evidence for the prevalence of a feminized poverty is the rate of poverty among children, who disproportionately reside in female-headed households" (p. 1).

Stressors Involved in Multiple Roles of Women

There is an incompatibility between work and family roles. For example:

1. Employed women are more likely to lack fringe benefits needed to care for their family (Paludi & Neidermeyer, 2008).
2. Employed women are more likely to lack job flexibility in order to care for themselves, children, and elderly parents (Paludi et al., 2008).
3. Women face the opportunity gap, factors that bar women from advancing in their careers at the same rate as men (Jandeska & Kraimer, 2005).
4. Salary inequities remain, especially for women of color (Hewlett, 2002).
5. Employed women do substantially more caregiving to children and elderly parents than do men (Heymann, 2000; Strassel, Colgan, & Goodman, 2006).

The incompatibility between the workplace and family demands is exacerbated by a relative lack of provisions that would ease women's integration of these roles. Furthermore, the reality that most children are being raised in single-parent homes has been ignored. In addition, equality of the parenting and housekeeping roles has not been achieved (Flouri & Buchanan, 2002; Strassel et al., 2006). For example, women perform more housework than men, and this applies even for women in academia and the sciences (Hersch, 2009; Milkie, Raley, & Bianchi, 2009). According to research conducted by the United States Department of Labor, Bureau of Labor Statistics (2010):

1. Eighty-four percent of women and 63% of men perform housework.
2. Employed women do approximately twice the amount of child care as employed men (44 minutes versus 23 minutes during a 24-hour period).
3. Dual-career families follow traditional husband-wife roles. Women spend approximately 80 minutes more during a day on home and child care responsibilities while spending 1 hour less at work.

Heymann's (2000) research suggested that there is an impact on children's health when at least one parent is not achieving work/life integration, including:

1. Sick children have shorter recovery periods. They have better vital signs and fewer symptoms when their parents participate in their care.
2. The presence of a parent reduces hospital stays by 31%.
3. Children recover more quickly from outpatient assistance when at least one parent is involved in their care.
4. There is a significant impact on children's educational outcomes when parents are not achieving work/life integration. When parents are involved in their children's education, children achieve more at all grade levels.
5. Children's higher achievement in math and language is associated with the involvement of at least one parent.

6. Teens are less likely to drop out of school if at least one parent is involved in their studying.

Research has identified noted costs to women who integrate work and family roles. For example, employed women who report work/life conflict are as much as 30 times more likely to experience a significant mental health problem, including depression and anxiety, than women who report no such conflict (Gonzalez-Morales, Peiro, & Greenglass, 2006). Psychological symptoms associated with integrating these roles include isolation, guilt, self-consciousness, frustration, alienation, withdrawal from social situations, and decreased self-esteem (Karsten, 2006). Research has also identified a variety of physical health complaints among women integrating multiple roles, including but not limited to headaches, tiredness, lethargy, gastrointestinal disorders, eating disorders, and inability to concentrate.

Research has indicated that maternal employment has been related to positive impacts on children (Han, Waldfogel, & Brooks-Gunn, 2001). For example, daughters of employed mothers are more career oriented (versus home oriented) than daughters of full-time homemakers. In addition, daughters of employed mothers are more likely to pursue nontraditional careers than daughters of full-time homemakers. Maternal employment influences women's career development through its provision of a role model of women's employment (Gottfried, Gottfried, & Bathurst, 2002). Whether the mother is employed is not the most critical factor; rather, it is the mother's role satisfaction and assistance with integrating work/life roles that has the greatest impact on children.

Research has also noted that married women have higher rates of admission to mental health facilities than married men (Russo & Green, 1993). Marecek (1978) suggested that married women may experience a loss of independence and status as well as difficulties associated with the multiple roles of wife, mother, and employee, all of which can create stress and lead to mental illness. Furthermore, women are likely to have a major part of their identity tied to their ability to successfully establish intimate relationships. When the romantic relationship ends, they may experience emotional problems as a result of regarding themselves as a failure in terms of the cultural standards of femininity (Carnelley, Wortman, & Kessler, 1999).

Older Women and Mental Health Issues

Paludi and DeFour (2010) identified the fact that older women are at risk of control by others, including family members, caregivers, and health care workers. Older women experience dependency and a loss of self-reliance due to physical and/or mental impairments. These impairments lead to older women's need for help with even the most basic activities of daily living, including personal hygiene care, maintenance of the home, and handling finances. Furthermore, older women have chronic illnesses and debilitating disorders, including Alzheimer's disease, strokes, and heart disorders, that require care (Etaugh, 2008).

In addition, older women are unable to defend themselves against the impact of abuse and/or neglect. Older women are at increased risk for intimate partner abuse; sexual assault, including marital rape; caregiver abuse; and impaired access to employment or education (Paludi & DeFour, 2010). The impact of this abuse includes permanent physical damage, loss of confidence, confusion, and depression.

In addition, there is a double standard of aging in North American culture (Paludi, 2010; Sontag, 1979). Aging in women alters the qualities of femininity in a culture (e.g., attractiveness, desirability, and reproductive capacity). Since masculinity is identified with independence, autonomy, competency, and self-control, aging does not threaten these qualities (Etaugh, 2008). Consequently, middle-aged and older women are more dissatisfied with age-related physical changes than are middle-aged and older men. Often older women strive to achieve the facial features and physique of younger women through age-concealment techniques in order to be accepted by a culture that values young women (Chrisler, Gorman, Chapman, & Serra, 2010; Digman & Otte, 2010; Frederick, Peplau, & Lever, 2008).

Heilbrun (1991, p. 56) noted that “signs of age come upon women in our society like marks of the devil in earlier times.” Older women are informed of the social norms for “appropriate” fashion for their aging female body, including refraining from wearing bright colors; wearing revealing, suggestive styles; and masking body “transgressions” (Pruis & Janowsky, 2010).

CAUSES AND MENTAL HEALTH IMPACT OF VIOLENCE AGAINST WOMEN

Throughout the life cycle, women are victims of violence including rape, intimate partner violence, stalking, child sexual abuse, workplace violence, and sexual harassment (Lundberg-Love & Marmion, 2006). For example, during childhood and adolescence (Paludi & Denmark, 2011):

1. Ten percent of teen girls report they have experienced physical violence in their dating relationships.
2. Seventy-one percent of school-aged girls report being bullied.
3. Between kindergarten and 12th grade, more than 4.5 million children and adolescents are targets of sexual harassment by a teacher, administrator, or other school employee.
4. Approximately 30% of adolescent girls are victims of child sexual abuse.

Paludi (2010) noted that with respect to college women:

1. One in every 20 is raped.
2. Acquaintance rape is more common than stranger rape.

3. Fifty percent to 80% of rape victims know their assailant (Gerber & Cherneski, 2006).
4. Women ages of 16 to 24 are raped at rates four times higher than the assault rate of all women (Fisher, Cullen, & Turner, 2000).
5. Intimate partner violence impacts 10% to 44% of students, including being slapped, having objects thrown at them, or being pushed, grabbed, shoved.

Paludi and DeFour (2010) reported that approximately 1.5 million women between the ages of 45 and 64 are physically abused by their mates, and approximately 1.5 million older women living in institutions are victims of abuse annually.

Research has documented impact on survivors' areas of functioning, including emotional/psychological, physical or health related, career, interpersonal, and self-perception (Dansky & Kilpatrick, 1997; McCann, 2001; Waits & Lundberg-Love, 2008). Examples of emotional/psychological effects of violence include but are not limited to guilt, denial, withdrawal from social settings, depression, fear, anger, isolation, fear of crime in general, helplessness, shock, and decreased self-esteem.

The following are reported physical/health-related effects of violence: headaches, fatigue, respiratory problems, substance abuse, sleep disturbances, eating disorders, lethargy, and gastrointestinal disorders.

Career effects include changes in work habits, absenteeism, and changes in career goals, including leaving school or occupations in order to escape the violence. The impact that violence has on social and interpersonal relationships includes the following: fear of new people, lack of trust, changes in social networks, and withdrawal.

Violence against girls and women has been recognized as a major public health and human rights issue that is explained by unequal power relations and patriarchal values.

FEMINIST THERAPIES

As a feminist therapist, I am aware that our best work comes out of our experience as women working with women. Only if our theory remains close to and within the world of women can it be a truly woman-based theory. The viewpoint must be female rather than male, as it has usually been.

Hannah Lerman

These realities of women's mental health and illness outlined in the five priority areas have implications for psychotherapy for women. Several feminist therapies have been offered to assist women in finding support for issues relating to victimization, aging, poverty, and role conflict (e.g., Gilbert, 1999; Moor, 2010, 2011; Worell, 1980). Feminist therapies accept the idea that society's definitions of gender roles and the devaluation of women and femininity must cease (Marecek & Kravetz, 1998).

The following guidelines endorsed by feminist therapists have been outlined by Worell (1980, pp. 480–481):

1. Providing an egalitarian relationship with shared responsibility between counselor and client. The client is encouraged to trust her own judgment and to arrive at her own decisions. In contrast to many traditional counseling relationships, the client is never in a one-down position of having to accept counselor interpretations of her behavior or external prescriptions for appropriate living.
2. Employing a consciousness-raising approach. Women are helped to become aware of the societal restraints on their development and opportunities. Clients are helped to differentiate between the politics of the sexist social structure and those problems over which they have realistic personal control.
3. Helping women explore a sense of their personal power and how they can use it constructively in personal, business, and political relationships.
4. Helping women to get in touch with unexpressed anger in order to combat depression and to make choices about how to use their anger constructively.
5. Helping women to redefine themselves apart from their role relationships to men, children, and home; exploring women's fears about potential role changes that may alienate spouse and children as well as coworkers and boss.
6. Encouraging women to nurture themselves as well as care for others, thereby raising self-confidence and self-esteem.
7. Encouraging multiple skill development to increase women's competence and productivity. This may include assertiveness training, economic and career skills, and negotiation skills with important others who resist change.

In 2000, the Council of Representatives of the American Psychological Association adopted the Guidelines for Psychotherapy with Lesbian, Gay, and Bisexual Clients. These guidelines including having psychologists “strive to understand the ways in which social stigmatization (e.g., prejudice, discrimination, violence) poses risks to the mental health and well-being of lesbian, gay, and bisexual clients.” These guidelines also advise psychologists that homosexuality and bisexuality are not indicative of any mental illness.

Thus, feminist therapists believe that what has been called mental illness needs to be reconsidered (Bravo-Rosewater, 1984; Gilbert, 1999). Bravo-Rosewater recommended that psychotherapists should concentrate not on diagnosis per se but rather on the implications of the diagnosis. According to Bravo-Rosewater:

If a woman is diagnosed as depressed, what assumptions underlie that label? Is it assumed that women are generally unhappy individuals? Is it assumed that depressed individuals are hopeless? Is the appropriate remedy psychotherapy or chemotherapy or shock treatments? ... A feminist analysis of depression sees it as originating from women's role in society. ... A feminist treatment of depression, therefore, centers on an examination of

the environmental impact on the woman in treatment, historically and currently. Depression may be viewed as a coping skill or as a health reaction to an unjust situation. . . . The role expectations for women in our society and whether a given role is right for any particular woman needs to be critically examined. Feminist therapy aids in the reevaluating and renegotiating of specific roles and the rules governing those roles (pp. 272–273).

THE PRESENT BOOK SET

This four-volume set on women and mental disorders features scholarly research about the following major topics: women's unique life experiences (e.g., feminist identity, poverty, spirituality); roots of abuse, crime, and sexual victimization (e.g., date rape, intimate partner violence, hate crimes); common mental disorders (e.g., anorexia, bulimia, agoraphobia); and treatments and research (e.g., counseling girls with eating disorders, ethnocultural psychotherapy, treating depression, histrionic personality disorder, and treatment of substance abuse).

We take a multicultural approach to women and mental disorders, including discussing international migration experiences of Asian women, depression among Caribbean women, international perspectives on women's mental health, and therapeutic needs that vary by women's age, culture, and income. We also offer readers resources on women's mental health and mental disorders.

Thus, this book set addresses the four biases toward women that the field of psychology and psychiatry has held for years (Worell, 1990): androcentrism (the prototype of humankind based on men), gendercentrism (separate paths of development theorized for women and men), ethnocentrism (personality development is identical across national origins and races), and heterosexism (heterosexual orientation is normative). Our goal is that these four volumes stimulate additional research agendas on women and mental disorders and mental health that make all women central, not marginal, as has been done by the early psychoanalytic theorists.

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Chapter I

Is Feminism Good for Women?

Kristin J. Anderson

Despite the embracing by much of the U.S. mainstream of such feminist initiatives as advances in women's paid employment, the recognition of sexual harassment in the workplace, and Title IX for girls' education, feminists continue to be objects of scorn and pity. Feminists have been described as "angry women" (O'Beirne, 2006, p. xviii) with "persecution fantasies" (O'Beirne, 2006, p. xvi), who "shame men" (Mansfield, 2006, p. 11) and are "chronically dissatisfied" (O'Beirne, 2006, p. xv). From an antifeminist perspective then, it only makes sense that feminists would have higher occurrences of mental disorders, psychological adjustment problems, and relationship maladies. However, feminist psychologists have long argued that a feminist identity is good for women (Klonis, Endo, Crosby, & Worell, 1997).

This chapter reviews the empirical research on feminism as a protective identity for American women. First, I examine the psychological theory and research on the role that feminism plays in women's psychological well-being. I examine self-efficacy, mental health, body image, and heterosexual romantic relationships. Do women differ in these areas depending on whether or not they hold traditional gender-role attitudes? Do women differ in these areas depending on whether or not they identify as feminists? Finally, I address the empirical research on the impact of women's studies courses on women and men. A growing body of work on the benefits of women's studies courses finds changes in critical thinking skills, open-mindedness, participatory learning, and increased self-efficacy.

FEMINIST IDENTITY: TWO CONSTRUCTS

First, some definitions are in order. Although there are a variety of definitions for a feminist, common elements to most definitions are that a feminist recognizes that discrimination against women exists, she experiences a sense of shared fate with women as a group, and she wants to work with others to improve women's status (Murnen & Smolak, 2009). In the psychological literature on feminism, there are generally two ways of categorizing individuals' feminist status—determining profeminist attitudes via survey questions, and determining feminist identity by simply asking the individual if she is a feminist. In determining profeminist attitudes, researchers use surveys, such as Morgan's (1996) Liberal Feminist Ideology Scale, or Henley, Meng, O'Brien, McCarthy, and Sockloskie's (1998) Feminist Perspectives Scale. But the most common method of assessing profeminist attitudes is by measuring feminist identity development through Downing and Roush's (1985) stage model. Downing and Roush propose that feminist identity development progresses through a series of five stages: passive acceptance, revelation, embeddedness/emanation, synthesis, and active commitment.

Passive acceptance describes women who are unaware of or deny the existence of sexism. Movement into the second stage, revelation, is precipitated by a crisis that forces a woman to recognize inequality. This crisis might be a personal experience of discrimination. The embeddedness/emanation stage represents a time for discovery of sisterhood. Women in this stage look for support from other women and begin to appreciate creative work by women (e.g., art, music, drama). Stage four, synthesis, is achieved when women value the positive aspects of being women and integrate these qualities with their own personal attributes for a positive and realistic self-concept. Finally, active commitment involves translating the newly consolidated feminist identity with action for social change. Various paper-and-pencil measures have been used to determine individuals' stage of feminist identity development. Interestingly, the scales that assess profeminist attitudes and feminist identity development do not assess explicit feminist self-identification ("I am a feminist") and rarely even use the word "feminist."

The second way of measuring feminist status is by assessing feminist identification. This typically involves simply asking the respondent, "Do you consider yourself a feminist?" One limitation of this approach is that contemporary young women (and men) do not necessarily know what a feminist is. For instance, in my own work (Anderson, Kanner, & Elsayegh, 2009), when I have asked respondents to define feminism, some confused it with "feminine" or described feminists as "women who think they are superior to men." Thus, it is important to control for accurate definitions of feminism. Profeminist attitudes, which assess one's stage of feminist identity development, and feminist identity, which measures one's explicit identity as a feminist, are correlated; however, they remain distinct constructs (Eisele & Stake, 2008). Whereas most women do endorse feminist attitudes, relatively few women call themselves feminists. As I review the relationship between feminism and mental health, these two different measures of feminism should be kept in mind.

MENTAL HEALTH AND WELL-BEING

Psychological Well-Being and Feminism

Yakushko (2007) classified a sample of women (mostly White) into those with traditional values, those with moderate values, and those with feminist values, based on their responses to a survey of feminist identity development. She examined several aspects of psychological well-being, such as autonomy in life (the degree to which someone is self-determining, independent, able to resist social pressure), personal growth (the feeling of continued development, openness to new experiences), environmental mastery (a sense of competence in managing one's environment), self-acceptance (possessing a positive attitude about the self, accepting good and bad qualities), purpose in life (having goals and a sense of directedness), and positive relations with others (having warm, trusting relationships with others; concern about the welfare of others). In general, scores on these measures of psychological well-being were higher among women with feminist values than among women with traditional values. Specifically, traditional women had lower scores on autonomy in life and personal growth than did moderate and feminist women. Women with traditional values also had lower scores on sense of purpose in life than did feminists. The three groups of women did not differ on measures of environmental mastery, positive relationships with others, self-acceptance, and general satisfaction with life.

These differences indicate that women who hold traditional values may experience less subjective well-being in life than women who ascribe partially or fully to tenets of feminism. Specific aspects of these women's identities that may especially contribute to their lower sense of well-being are their lower scores in the areas of autonomy, personal growth, and purpose in life. Perhaps traditional women do not view these aspects of well-being as significant to their lives. For example, they may see their role in life as being dependent on and supportive of others, promoting the growth and well-being of others around them, rather than being autonomous (Yakushko, 2007).

Saunders and Kashubeck-West (2006) also explored the relationship between feminist identity development, and psychological well-being and gender-role orientation in an ethnically and socioeconomically diverse sample of women. Higher levels of feminist identity development were associated with psychological well-being in general, although not with their specific measures of well-being (e.g., autonomy, mastery of one's environment, personal growth, relations with others, purpose in life, and self-acceptance). In addition, instrumental (i.e., male-stereotyped) and androgynous gender-role orientations were associated with psychological well-being. Other studies also have found that having a feminist orientation or being a member of a feminist organization is positively related to a more androgynous or stereotypically masculine gender-role type (Baucom & Sanders, 1978; Jordan-Viola, Fassberg, & Viola, 1976).

The Yakushko (2007) and Saunders and Kashubeck-West (2006) studies both measured profeminist attitudes via measures of feminist identity development.

Other studies (e.g., Eisele & Stake, 2008) find that feminist attitudes tend to be indirectly related to self-efficacy, whereas the link between feminist identity and self-efficacy is direct.

THE ANGRY FEMINIST?

One widespread and durable stereotype about feminists is that they are angry. Feminist consciousness provides a cognitive framework for understanding the world, especially experiences of prejudice and discrimination from others. Feminists have the tools to frame the sexist discrimination they may experience as constitutionally unjust and as resulting from their status as women (Fischer & Good, 2004). Fischer and Good asked a sample of women (mostly White) to complete a feminist identity development measure to assess the stage of their feminist attitudes. The respondents also completed the Trait Anger Expression Inventory and the Symptoms Checklist, which measures a range of problems including anxiety, phobias, and paranoia. Are any of the stages of feminist identity development linked to psychological distress and anger? Only the revelation stage shows substantial links with psychological distress and anger. Revelation is only the second stage of feminist identity development, at which women first begin to recognize gender inequality. Revelation-like experiences may be overwhelming and could contribute to a generalized state of anger, particularly given that the cognitive awareness of patriarchal injustices is so new at that point. So, contrary to the angry feminist stereotype, it is only early awareness of sexism that is associated with anger. The more mature stages of feminist identity—those stages that would constitute a feminist identity—are not associated with anger.

RELATIONSHIPS

In addition to the angry-feminist stereotype, another set of stereotypes about feminists is that they are physically unattractive, they do not have successful relationships with men or are even scorned women, and they are lesbians (Anderson, 2010). In his book *Manliness*, Harvey Mansfield describes feminists as “anti-male” and states that feminists are “none too pleased with men and not shy about letting them know it” (Mansfield, 2006, pp. 4, 5). Antifeminist author Kate O’Beirne said, “I have long thought that if high-school boys had invited homely girls to the prom we might have been spared the feminist movement” (Lopez, 2005). These stereotypes can serve as a barrier to feminist identification, preventing young women (and men) from identifying as feminists and working on behalf of women’s rights.

Is Feminism Bad for Relationships?

Women and men alike tend to think that feminism is incompatible with heterosexual romance. For instance, Rudman and Fairchild (2007) found that people tend to believe that unattractive women are likely to be feminists (and lesbians). And women who rate themselves as attractive tend to have more antifeminist attitudes

than women who do not rate themselves as attractive. Of course, these findings may speak more to the perceptions that feminists are unattractive than the reality that feminists are unattractive. Perhaps feminists resist traditional heterosexual beauty norms by not thinking of themselves in terms of looks, or by not spending a great deal of time on their appearance. Also, women who are not feminists may be more committed to romantic ideals and may therefore report themselves to be more attractive in order to be consistent with this ideal.

In terms of heterosexual relationships, participants who believed that feminism is threatening to romance also showed less enthusiasm for feminists and even for policies that support women. These results support Rudman and Fairchild's hypothesis that romance-related concerns about feminism may be an important barrier to gender equity. Romantic concerns about feminism have negative implications for the progress of the women's movement because beliefs about the incompatibility of romance and feminism decrease support for feminism. If intimate relationship concerns undermine feminism's appeal, then these concerns will also undermine collective action on women's behalf. As a result of these beliefs, people may view feminism as unromantic and a hindrance to their own relationships. Indeed, beliefs that feminism is problematic for heterosexual relationships negatively predict feminist identity, feminist attitudes, and support for women's civil rights (Rudman & Fairchild, 2007).

Is feminism actually incompatible with heterosexual romantic relationships? A study on feminists' and nonfeminists' romantic relationships does not find support for the results just described. Rudman and Phelan (2007) examined whether (mostly White) heterosexual feminists (or men paired with feminists) have troubled romantic relationships, as is popularly perceived. Contrary to stereotypes, feminists were more likely to be in romantic relationships than nonfeminist women. Feminist women did not report decreased relationship quality and stability, although they tended to report more conflict regarding equality in the relationship compared with nonfeminist women.

Feminist men are important for heterosexual women's relationship health. Rudman and Phelan (2007) found that women reported greater relationship quality, equality, stability, and sexual satisfaction to the extent that they perceived their partner to be a feminist. Because feminist women tend to select feminist men as partners, feminism for women may have an indirectly positive influence on their relationships. What about men who are in relationships with feminist women? Feminist men report greater agreement about relationship equality than did nonfeminist men. Also, men reported greater relationship stability and sexual satisfaction to the extent that their partner was a feminist. Therefore, feminism may also be healthy for men's relationships. Thus, the overall pattern for men suggests that feminism (for self and partners) may be beneficial for their relationships, rather than problematic.

Expectations and Inequality

Feminist attitudes and gender-role attitudes predict women's (and men's) expectations about equality in intimate heterosexual relationships. For instance,

women with traditional gender-role attitudes who do not endorse feminist ideology tend to have lower expectations for egalitarian romantic relationships than those with nontraditional attitudes (Yoder, Perry, & Saal, 2007). In fact, compared with women who endorse feminist attitudes, women who do not are likely to have lowered expectations for egalitarian long-term relationships, both in general and across such specific aspects of long-term relationships as the balance of power, division of household labor, sharing of child care, participation in social and community activities outside the home, importance of education for each spouse, and employment options and responsibilities. Not endorsing feminist attitudes is even associated with less sexual assertiveness overall, particularly in the areas of initiation and safe sexual practices (Yoder et al., 2007). Similarly, Askari, Liss, Erchull, Staebell, and Axelson (2010) found that women and men with nontraditional gender-role attitudes expected to share in child care (although, curiously, not in household chores) with their partners, whereas women and men with traditional attitudes expected the traditional unequal division of labor.

Feminists and individuals with nontraditional gender attitudes put a high premium on equity relative to nonfeminists and those with traditional gender attitudes. Women and men with traditional gender-role self-concepts (i.e., men as instrumental, women as expressive) seem to accept greater inequality in their relationships compared to women and men with nontraditional gender-role self-concepts (Donaghue & Fallon, 2003). Women and men with nontraditional gender-role self-concepts report that a change in the equity of their relationship would be disturbing. In other words, nontraditional women are sensitive to being put in the traditional position of underbenefiting in terms of domestic duties, and nontraditional men are sensitive to being in the privileged position. However, this is not the case for traditional women and men. Traditional men seemed concerned about losing their privileged position. Traditional women did not expect that they would be highly affected by a lack of equity in their relationships, perhaps reflecting the belief that women and men contribute different things to their relationships and that a comparison of the relative value of these contributions is unhelpful or irrelevant. In summary, women and men with nontraditional attitudes put a high price on equity, whereas traditional women and men are more accepting of women's inequity and are less disturbed by it.

SEXUAL RELATIONS

Gender-related attitudes affect one specific aspect of heterosexual relationships, namely sexual behavior. Schick, Zucker, and Bay-Cheng (2008) examined the relationship between feminist attitudes toward condom-use self-efficacy and sexual satisfaction among women (mostly White). Women who endorse feminist attitudes felt a greater sense of sexual subjectivity and were more inclined to have sex as a result of their own sexual interests and wishes rather than in response to extrinsic forces (e.g., pressure from their male partners). Although they hypothesized that feminist ideology, with its critique of sexually disempowering

gender norms, would be linked to sexual subjectivity, analyses indicated that feminist identity was directly related to sexual motivation as well. Given the relations of sexual subjectivity and sexual motivation to condom-use self-efficacy and sexual satisfaction, these findings suggest that young women who endorse feminist beliefs may be sexually safer as well as more satisfied with their sexual experiences (Schick et al., 2008). These findings correspond with other work finding that women with traditional gender-role attitudes who do not endorse feminist ideology tend to demonstrate less sexual assertiveness and are less likely to practice safe sex (Yoder et al., 2007).

In another study of mostly White female university students, Bay-Cheng and Zucker (2007) compared self-identified feminists with nonfeminists and egalitarians—women who endorse feminist ideology but do not identify as feminist—on a variety of measures related to sexual beliefs and behavior. Feminists also expressed greater erotophilia (one's positive affective and evaluative responses to sexual cues) than nonfeminists, and egalitarians did not differ from either group. Feminists expressed significantly less support for the sexual double standard (e.g., believing that promiscuity is okay for men, but not for women) than did nonfeminists and egalitarians. There were no significant differences among feminists, egalitarians, and nonfeminists on measures of sexual assertiveness or sexual satisfaction. One noteworthy difference between egalitarians and the other two groups is that egalitarians felt more confident in their abilities to assert their wishes regarding condom use than did nonfeminists and feminists. Why do feminists feel less confident than egalitarians in their ability to assert the need for condom use? One possibility, according to the authors, is that feminists are more aware of and therefore feel more susceptible to gendered power differentials between women and their male partners. This reasoning suggests that feminists believe larger external conditions, such as sexism and unequal access to social power, impinge on individual women's ability to advocate for themselves in the sexual arena, regardless of their interest in doing so. Egalitarians, on the other hand, empowered by the discourse of self-determination and individual entitlement, may not perceive gendered scripts or sexism as threats to their own sexual agency. As a result egalitarians may have the subjective perception of greater self-efficacy with regard to condom-use assertiveness. It's important to note that this difference between feminists and egalitarians is limited to subjective perception; egalitarians did not report higher rates of actual condom use than their feminist or nonfeminist counterparts.

The internalization of traditional feminine gender socialization plays a role in women's sexual behavior. Sexual compliance is the consensual acquiescence to sex despite a lack of sexual desire. Katz and Tirone (2009) found that sexually compliant women reported a greater investment in ideal womanhood compared to other women. These findings are consistent with the idea that an investment in feminine gender norms may lead women to voluntarily submit to unwanted sex to avoid deviating from their prescribed gender role as passive keepers of peace and relational harmony. Because sexually compliant women reported less relationship satisfaction than other women, it appears that women who adhere to

gender-socialization messages that foster sexual compliance are at risk for feeling resentful or used, or for experiencing other negative emotions about the relationship. One might guess that women's sexual compliance might enhance romantic well-being—at least in the context of traditional heterosexual relationships. However, Katz and Tirone's (2009) data fail to find a connection between women's sexual compliance and romantic well-being. Compared to noncompliant women, sexually compliant women reported less relationship satisfaction, although they did not differ from noncompliant women in their commitments to their relationships. Women most frequently engage in compliant sex because they believe it will make their partners happy. However, the evidence failed to show that compliance helps women feel more romantically happy themselves.

Internalizing the norms of traditional femininity might conform to society's expectations about how to be a good girl or woman, but it can have a negative effect on negotiating sexuality issues. For instance, one study found that among 12th-grade American girls, those who internalize norms of traditional femininity tend to be unable to act on their own desires in sexual relationships. Specifically, girls who have an objectified relationship with their bodies (e.g., think that a girl has to be thin to be beautiful, are more concerned with how her body looks than feels) and an inauthentic self in relationships (e.g., telling people what they want to hear, holding back opinions) are less likely to refuse unwanted sex, insist on using protection, and enjoy sex (Impett, Schooler, & Tolman, 2006). This study isn't about feminism per se, but girls with traditional gender attitudes tend to be nonfeminists and vice versa.

Looking at friendships among women, Rose and Roades (1987) compared the types of friendships between women who identified as heterosexual feminists, heterosexual nonfeminists, and lesbian feminists (no information on ethnicity). First, there were no differences between feminists (lesbian or heterosexual) and nonfeminists in number of close women or men friends—another debunking of the myth that feminists (and lesbians) dislike men. Second, no differences emerged between the three groups in liking, loving, satisfaction with the friendship, or importance of the relationship to the individual. The most significant differences were between heterosexual feminists and heterosexual nonfeminists. First, feminists avoided friendships with nonfeminist women. Second, compared to nonfeminists, feminists had more women friends at least 10 years older or younger than themselves. This point about intergenerational friendships among feminist women is significant because one lament of the lack of a coherent feminist movement in the 21st century is the absence of an intergenerational transfer of feminist consciousness from older to younger emerging feminists (Anderson, in press). And finally, feminists' friendships were reported to be more equal and democratic than nonfeminists' friendships.

The literature on the relationship between feminist identity and attitudes and heterosexual relationships demonstrates that being a feminist or holding feminist attitudes does not negatively influence women in heterosexual relationships. In fact, the preponderance of the research suggests that feminism is good for relationships, especially for women and perhaps even for men.

BODY IMAGE

Feminist psychologists have argued that a feminist identity protects women from internalizing the damaging effects of female body objectification so common in Western culture. At the beginning of this chapter I discussed the difference between profeminist attitudes, measured by surveys, and feminist self-identity. Self-identified feminists may be more likely than women who simply hold feminist beliefs without taking on the socially stigmatized label to reap benefits associated with rejecting norms of beauty and thinness. A recent meta-analysis addresses the role of feminism in women's body-image problems. Murnen and Smolak (2009) conducted a meta-analysis compiling the results from 26 studies (almost all North American) examining whether a feminist identity protects women from body-image problems. They predicted that women who identify as feminists would have more positive body attitudes and less disordered eating than would those who simply agreed with feminist principles. Most of the data show only weak relationships between feminist identity and attitudes and thoughts related to the body. Nonetheless, there were still several significant associations between feminism and body attitudes. Consistent with much of the work I have reviewed thus far, this association was strongest when feminist self-identification was the measure of feminism. In other words, those women who call themselves feminists are more likely to have positive attitudes about their bodies compared to women who simply hold profeminist attitudes and nonfeminists. Murnen and Smolak (2009) found that feminist identity was associated with a lower preoccupation with thinness and with lower scores on eating-disorder inventories. Also, feminists were less likely to internalize media messages about thinness than were nonfeminists. That is, feminist women are more resistant to media images that glorify thinness. Women who report body shame are believed to have internalized the cultural messages that they should be thin, that they should be able to control their weight, and that they are not worthy individuals otherwise. A feminist identity seems to provide some protection against this internalization. It is likely that feminism helps women critically evaluate and perhaps avoid harmful cultural messages. Overall, the authors report that compared to other meta-analytic findings, the association between feminist identity and (lack of) body shame is one of the strongest "protective" effects they have found.

It should be noted that none of the studies that Murnen and Smolak analyzed looked at adolescents or younger girls. Also, there were no differences in the relationship between feminist identity and body image by ethnicity, although few studies actually included diverse samples of women. Overall, this study suggests that feminism is a protective factor against body-image issues in three ways. A feminist identity should (1) lead to an elevation of critical thought; (2) emphasize collective action; and (3) may empower women to act more in their own self-interest than to blindly follow the dictates of society that women should focus on their bodies (Murnen & Smolak, 2009).

THE IMPACT OF WOMEN'S AND GENDER STUDIES

The 1970s ushered in a high point in the second wave of feminism in the U.S. During this successful era, women's studies programs and courses in college curricula were launched across the United States. Women's studies offered an entirely new subject matter as well as a rereading of conventional curricula. The main contribution of women's studies curricula was the movement of women's perspectives from their previously marginalized positions to the center of inquiry.

Thus far, we have examined the role that profeminist attitudes and feminist identity have on women's mental health, well-being, and body image. This final section looks at the impact that women's and gender studies courses have on women. If feminist attitudes and feminist identity have a generally positive impact on women, is feminist coursework likely to influence women to become feminists? And do women's and gender studies courses influence women in other ways that we have examined, such as self-esteem/self-efficacy, empowerment, and the likelihood of engaging in activism? These questions are addressed below. Much of the empirical research on the experience of women's and gender studies (WGS) courses entail quasiexperimental, pre/postdesigns in which students are assessed on various dimensions at the beginning and then the end of a course. Pretest and posttest scores are compared between students taking WGS courses and "control" students taking non-WGS courses. Unfortunately, like the work I have reviewed thus far, much of this work includes mostly White samples, and thus few ethnic comparisons are made.

Consistent with the goals of WGS courses, WGS students tend to become more liberal in their gender-related attitudes than those students who take non-WGS coursework (see Macalister, 1999, for a review). Also, women in WGS courses are more likely to identify as feminists by the end of the coursework than those in a control group (Bargad & Hyde, 1991). Students who have taken a women's studies course are more likely to view gender differences as being the result of socialization than as biological (Yoder, Fischer, Kahn, & Groden, 2007).

When WGS courses were first developed, one of the hopes was that these courses would play some role in the empowerment of women. Some studies have examined this construct directly or indirectly. Harris, Melaas, and Rodacker (1999) examined locus of control before and after a women's studies course. Locus of control is a construct that represents an individual's sense of personal control over the events in her life. Individuals with an internal locus of control believe that they have agency and an impact on determining their own fate. In their study of mostly White U.S. college students, Harris et al. found that by the end of their course WGS students displayed a more internal locus of control than did non-WGS students. These changes were experienced by both women and men. Another study examined whether or not women's general personal self-efficacy scores changed over the course of a semester (Eisele & Stake, 2008). African American and White women's general personal self-efficacy scores increased over the course of the semester. In contrast, men's general personal self-efficacy declined somewhat over the semester, which is inconsistent with previous research. Perhaps some

of the men in the sample had not been exposed to awareness of male privilege. Maybe this new information dampened their feelings of self-efficacy with the realization that their successes were not based solely on their effort and talents but also on biases that favor them.

The research on WGS coursework on self-esteem is somewhat inconsistent. Stake and Gerner (1987) found that WGS students had higher posttest scores on performance self-esteem than did controls. This was the case for both women and men WGS students. The lack of gender differences suggests that women's studies classes may act as a change agent for men as well as women. Another study (Harris et al., 1999) tested for changes in self-esteem after taking WGS courses and found that there were no increases in self-esteem among WGS students. Finally, Zuckerman (1983) found a pattern associated with self-esteem and undergraduate grade/class-level. Lower-level WGS students experienced a decline in self-esteem, while upper-level WGS students experienced an increase in self-esteem after having taken a women's studies course. WGS classes might serve different purposes for younger than older students: younger students may be gaining awareness about sexism and inequality rather than building self-esteem, whereas older students might be gaining empowerment.

WOMEN'S STUDIES: A TRAINING GROUND FOR MAN-HATING?

A particular concern about the impact of women's studies courses comes from the political right. Women's studies programs are caricatured as anti-male training grounds. For instance, in 2005, when the Pentagon attempted to establish the Office of the Victim Advocate to handle hundreds of sexual-assault claims made by women soldiers against men soldiers, antifeminist Elaine Donnelly (2005), the president of the Center for Military Readiness, described the effort as establishing an "Office of Male-Bashing" (p. 7). She predicted that the office would "create a new job market for 'women's studies' graduates schooled in man-hating ideology." The impact on gender-related attitudes after exposure to WGS courses has been central for feminists as well.

Pence (1992) addressed this issue when he compared attitudes toward men among women taking a women's studies course with those taking an African American studies or introductory sociology course. Using the typical pretest/posttest procedure, Pence found that over the course of the semester, women's attitudes toward both nontraditional masculine behaviors (e.g., men taking care of children) became more supportive and their attitudes toward men as men also improved. This attitude change occurred in women taking the women's studies course. Furthermore, those women who enrolled in women's studies for personal interest had more positive attitudes (on both pretests and posttests) toward men than did those who took the course because of a requirement. The author explains that even though men were, at most, peripheral to the course content, by semester's end these students saw men as gendered beings whose roles and behaviors were also socially constructed. This provides a context for why men

act the way they do. By the end of the course, students established a gendered framework for understanding women's and men's attitudes and behaviors. The results of Pence's study are consistent with another study finding that feminists actually have more positive attitudes toward men than do nonfeminists (Anderson et al., 2009). The assumption that WGS is hostile toward men contributes to the marginalization of these courses among faculty and students and trivializes what is actually occurring in WGS courses.

Perhaps one of the most important influences of WGS courses is the creation of new activists. Stake (2007) found that among African American and White (but not Asian American) students, those who took WGS courses were more likely to engage in activism than students who did not take WGS courses. Cultural values of rule compliance and deference to authority might explain why Asian American students did not report activist behavior (Sue & Sue, 1999). Activism is important for meaningful societal change because it involves personal, direct, grassroots efforts on the part of students. Students have increased feelings of empowerment and feel like they can have an impact on the world. Women's increasing commitment to meaningful activism is linked with expectations for egalitarian partnerships in general, as well as for authority, homemaking, child care, education, and employment support (Yoder, Perry, & Saal, 2007).

In the same study, Stake (2007) found that the emotional responses of the WGS students fits the pattern of activist emotions, with little increase in distress or anger but a substantial increase in feelings of empowerment. Interestingly, although activist intentions were predicted by both awareness of sexism and profeminist attitudes, only awareness of sexism predicted activist behaviors. Stake notes that flexible, egalitarian attitudes may be useful in getting individuals to consider the possibility and viability of participating actively for women's rights yet may not be independent enough of a strong awareness of sexism to propel them to action.

The empirical research on the impact of women's and gender studies courses demonstrates a variety of positive effects on women (and, in some cases, men as well), such as increased locus of control, self-efficacy, and feelings of empowerment and activism. One limitation of most of the studies on the impact of WGS is that we do not know much about the long-term effects of taking such classes, although one study found that students' lessons from the courses were sustained over a nine-month period (Stake & Rose, 1994).

CONCLUSION

Many political commentators and women themselves dismiss feminism as part of the past, as unnecessary for women today. Women have made concrete progress in the areas of paid employment, education, and politics. Those who still insist on identifying as feminists or insisting on a feminist movement are viewed as angry, dissatisfied, and male-bashing (Anderson, in press). In this chapter, I reviewed the literature on the role that feminism plays in women's psychological well-being, as well as heterosexual romantic relationships and body image. I ended with a

review of the research on the influence of women's and gender studies courses on women. Contrary to popular stereotypes, in almost all areas of review, feminist attitudes, and feminist identity even more so, have positive effects on women's psychology and relationships. There are essentially no areas in which being a nonfeminist is helpful to individual women.

There are just a few final thoughts about the body of research I reviewed. First, women's holding of profeminist attitudes is beneficial. However, taking the extra step of identifying as a feminist is better. We find this for self-efficacy (Eisele & Stake, 2008), heterosexual romantic relationships (Rudman & Phelan, 2007), sexual behavior (with the exception of assertiveness in condom use; Bay-Cheng & Zucker, 2007), and in body image. Second, the work described here is correlational. It is not clear whether psychological well-being in the form of self-efficacy, internal locus of control, and feelings empowerment creates the opportunity to become a feminist or whether feminism causes positive changes in well-being.

Third, most of the research studies examined here include samples consisting of White women. Like much psychological research, even in the 21st century, too few studies include significant numbers of people of color. American women of color have had an ambivalent relationship with the modern women's movement (Anderson, 2010), making the impact of feminist attitudes and identity in women of color a most necessary area of research. Similarly, much of the recent psychology studies on feminism and feminists include heterosexual women but not lesbians or bisexual women. Like women of color, lesbians have had an ambivalent relationship with the modern women's movement; the impact that feminist consciousness has on sexual-minority women is most necessary. In particular, the work on feminism and relationships almost exclusively examines heterosexual relationships. The role that feminist consciousness plays in lesbian relationships is understudied. The role of being a feminist who is also a sexual minority should impact well-being, although we do not know how.

Finally, I end with two questions. This chapter reveals many positive (and essentially no negative) relationships between feminism and psychological well-being. This fact makes all the more curious the stigmatization of feminists and feminism. What function is served by maintaining the fiction that feminism is bad for women? What institutions and individuals benefit from the maintenance of this myth?

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Chapter 2

Femininity and Women's Psychological Well-Being

Munyi Shea and Y. Joel Wong

Why do women have higher rates of eating disorders than men (Striegel-Moore & Bulik, 2007)? Why are some women more vulnerable to psychological distress than other women? What contributes to women's well-being? In this chapter, we seek to address these questions by focusing on the influence of femininity on women's well-being. Although there are diverse forms of well-being, we focus mainly on women's psychological well-being, which includes constructs such as mental health, self-esteem, self-efficacy, body image, and life satisfaction. Additionally, we define femininity as a multifaceted construct that determines the meanings associated with being female. Theories of femininity address questions such as the process through which women relate their behaviors to gender and how women develop conceptions of what women should or should not do.

A central thesis of this chapter is that theories about femininity influence our conceptualizations of women's psychological well-being. We review three theoretical perspectives on femininity and their implications for women's psychological well-being. We begin with the personality traits perspective, which views femininity as a cluster of socially desirable attributes that define feminine personality. Next, we examine the gender-role socialization perspective on femininity, which emphasizes social influences on women's lives. Finally, we conclude with the social constructionist perspective, with an emphasis on a

new theoretical model—the Subjective Gender Experiences Model. It is worth noting at the outset that each of these three perspectives should not be viewed as a distinct theory but rather as a constellation of related theories.

PERSONALITY TRAITS PERSPECTIVE

Personality traits perspective views masculinity and femininity as socially desirable, gender-role appropriate personality traits (Bem, 1974). Femininity is related to expressive, communal attributes—such as being “warm,” “kind,” and “compassionate”—that are found to be more characteristic of females than of males, whereas masculinity is associated with instrumental, agentic personality qualities, such as being “decisive,” “self-reliant,” and “independent” (Bem, 1974).

Bem (1981a, 1993) posited that society's emphasis on gender dichotomy gives rise to specific roles and personality attributes associated with each gender. Children begin to develop gender schema—a lens through which they process and organize information about themselves and the world—as they come to understand the concepts and implications of femininity and masculinity. For instance, children may learn that femininity is associated with nurturance, affiliation, and passivity, whereas masculinity is associated with autonomy, self-reliance, and achievement. As a result of the gender socialization, persons learn to orient their beliefs, abilities, preferences, and behaviors to these cultural expectations of gender-appropriate roles and attributes. There are degrees of differences in a person's identification with stereotypic characteristics of femininity and masculinity. A person who identifies her/himself strongly with gender stereotypes is likely to fulfill traditional gender roles and demonstrate gender-stereotypic traits and behaviors.

Among the instruments that measure gender-role related traits, the Bem Sex Role Inventory (BSRI) (Bem, 1974; 1981b) and the Personal Attributes Questionnaire (PAQ) (Spence, Helmreich, & Stapp, 1974) are commonly cited. These scales measure the extent to which persons identify with and orient themselves along traditional sex-typed roles and behaviors. The BSRI consists of personality traits that are more socially desirable for one sex than for the other, whereas the PAQ is comprised of attributes that are more stereotypically true for one sex than for the other. These scales regard femininity and masculinity as two independent dimensions rather than a unidimensional, bipolar construct. Hence, it is possible for a person to identify with both feminine and masculine gender-role traits. Persons who have high feminine and masculine gender-role orientations are classified as androgynous. Persons who show low endorsements of either feminine or masculine gender-role-related traits are defined as undifferentiated (Bem, 1974).

Gender Personality Traits and Psychological Well-being

Research consistently noted higher rates of depression in females than males (Angst, Gamma, Gastpar, Lépine, Mendlewicz, & Tylee, 2002; Hilt & Nolan-Hoeksema, 2009) across socioeconomic class, racial-ethnic groups, and community and clinical samples (Grant, Compas, Thurm, McMahon, & Gipson,

2004; Nolen-Hoeksema & Girgus, 1994). Gender differences in depression tend to emerge during adolescence and persist into adulthood (Hilt & Nolen-Hoeksema, 2009; Nolen-Hoeksema & Girgus, 1994; Petersen, Compas, Brooks-Gunn, Stemmeler, & Grant, 1993). Eating disorder is another clinical area that highlights female differential vulnerability. Women are three times more likely than men to experience anorexia and bulimia (Hudson, Hiripi, Pope, & Kessler, 2007). Women and girls also tend to report more concerns about physical attractiveness than men and boys (Mintz & Betz, 1986).

While feminine and masculine personality traits have been implicated in female psychopathology, the relationships between gender-role traits and psychological health remain unclear. Some studies suggested that a feminine personality style tends to predict depressive symptoms among adolescent girls (Aube, Fichman, Saltaris, & Koestner, 2000) and eating disorders symptomatology among women (Murnen and Smolak, 1997; Sitnick & Katz 1984; Steiger, Fraenkel, & Leichner 1989; Williams & Ricciardelli, 2001). Other studies, however, found that higher femininity is related to lower ratings of depressive symptoms among women (Dyson & Renk, 2006; Steenbarger & Greenberg, 1990; Waelde, Silvern, & Hodges, 1994) and may serve as a protective factor for women in the face of high interpersonal stress (Steenbarger & Greenberg, 1990; Waelde et al., 1994). Moreover, undifferentiated women (low femininity and low masculinity) were at higher risk for bulimia than androgynous (high femininity and high masculinity) women (Pritchard, 2008). Finally, some studies reported no effects of femininity on depression (Craighead & Green, 1989; Nezu & Nezu, 1987; Whitley, 1985), suicidality (Waelde et al., 1994), or eating disorders (Timko, Striegel-Moore, Silberstein, & Rodin, 1987).

Two interpretive models—the masculinity model and the androgyny model (see Whitney, 1983)—were put forth to understand these mixed research findings. The masculinity model suggests that masculine traits (or a masculine gender orientation) are related to better psychological health and adjustment, including lower levels of depression, anxiety, and hostility (Markstrom-Adams, 1989; Rose & Montemayor, 1994), regardless of biological sex (Bassoff & Glass, 1982; Taylor & Hall, 1982). Men or women with masculine traits (e.g., independence, assertiveness) are more likely to engage in problem-focused coping behaviors and to perceive their own problem-solving ability as more effective (Nezu & Nezu, 1987), which lead to an enhanced sense of self-efficacy that may serve as a buffer against depression, anxiety, and stress. On the other hand, feminine traits (or a feminine gender orientation) are linked with increased likelihood of depression. Nolen-Hoeksema and Girgus (1994) found that one of the risk factors for higher rates of depression among adolescent girls (than boys) is their identification with traditional feminine traits (e.g., passivity, affiliation) starting at a young age. Gender socialization may predispose girls to identify with feminine personality traits and encourage greater use of passive or emotion-focused coping strategies (Nezu & Nezu, 1987), which result in a sense of “learned helplessness” (Weissman & Klerman, 1987). It is possible that girls become more

self-conscious throughout adolescence; they become more concerned with their body image and interpersonal relationships, more accommodating, and more likely to sacrifice their own needs for those of others (Hill & Lynch, 1983). When the preexisting risk factor—a stereotyped feminine gender orientation—interacts with increasingly stressful experiences during adolescence (e.g., changes in physical appearance, interpersonal conflicts), it may render adolescent girls more susceptible than boys to the negative impact of life events and to depression (Nolen-Hoeksema & Girgus, 1994). Furthermore, the view that feminine traits are less socially esteemed than masculine traits (Landrine, 1988) could aggravate women's feelings of "social powerlessness."

Several concerns about the masculinity model were raised. First, masculinity measures tap constructs of self-efficacy, self-confidence, and instrumentality; these constructs are theoretically inconsistent with the construct of depression (Whitley, 1985; Whitney, 1985). Hence, masculinity is likely to demonstrate a negative correlation with depressive symptoms. Second, it is important to consider how "well-being" was defined in previous studies when examining the relationship between gender-role traits and adjustment outcomes. Many studies used achievement-related tasks (e.g., academic performance) as outcome variables or employed measures that emphasize agentic (masculine) attributes (e.g., independence, assertiveness) (Cheng, 2005), thereby yielding results that were in favor of a masculine gender orientation. Cheng argued that agentic attributes and communal (feminine) attributes are effective for different situations. While agentic attributes may facilitate coping with achievement-oriented stressful events (Waelde et al., 1994), communal attributes may be effective for managing stressful interpersonal events, such as marital discord and adjustment (Langis, Sabourin, Lussier, & Mathieu, 1994).

The androgyny model (Bem, 1975) posits that possession of both masculine and feminine traits is instrumental to psychological well-being. People who have higher levels of femininity or masculinity traits tended to perform well only in their respective, gender-appropriate tasks, whereas androgynous persons performed well in both communal and agentic tasks. Androgyny, rather than masculinity or femininity alone, is related to greater resilience to life stress (Roos & Cohen, 1987) and lower levels of depression across an array of stressful situations (Cheng, 2005). Compared to individuals who adhere to stereotypic masculine or feminine gender-role traits, androgynous persons might be less rigid and less concerned with applying gender-appropriate coping strategies. They are more attuned to adapting their coping strategies to the changing environment, demonstrating a greater degree of gender-role flexibility and ability to adopt the best-fit solution (Cheng 2005). Dyson and Renk (2006) found that endorsement of high levels of both femininity and masculinity traits were related to greater use of problem-focused coping strategies. In contrast to previous studies (Nezu & Nezu, 1987), they also reported that high levels of femininity traits not only predicted the use of emotion-focused coping strategies, but also predicted the use of problem-focused coping strategies among female college students. These findings suggest that androgynous persons use more balanced coping strategies and are more flexible in their problem-solving approaches.

The conflicting results may be in part due to measurement discrepancies. First, different measures were used to operationalize eating disorders (e.g., Eating Attitudes Test: Garner & Garfinkel, 1979; Eating Disorder Inventory: Garner, Olmstead, & Polivy, 1983) and femininity (e.g., Bem Sex Role Inventory: Bem, 1974, 1981b; Sex-Role Ideology Scale: Tilby & Kalin, 1980; Personal Attributes Questionnaire: Spence et al., 1974). Second, some studies included only masculine and feminine gender orientations, leaving out androgynous and undifferentiated orientations, whereas others included all four gender-role orientations (Pritchard, 2008). Third, researchers have noted that the common measures of gender-role traits (e.g., BSRI, PAQ) tend to assess positive femininity traits, such as compassion, warmth, and kindness. These positive attributes are less likely to pose risks for major mental health concerns. Hence, it may be difficult to establish a positive correlation between femininity personality traits and psychopathology (Brazelton, Greene, & Gynther, 1996; Martz, Handley, & Eisler, 1995).

Critiques of Personality Traits Perspective

A major critique of gender-role personality traits perspective is that it conceptualizes femininity as a collection of innate, global, and homogenous attributes, negating distinct sociocultural injunctions that may fine-tune women's beliefs, attitudes, and behaviors. Further, gender-role socialization tends to occur across the life span, rendering femininity a malleable construct (American Psychological Association, 2007). Additionally, femininity may have different meanings across diverse cultural groups. In their study, Lyons, Carlson, Thurm, Grant, and Gipson (2006) found that a feminine gender-role orientation was unrelated to poor body image or negative attribution—two common risk factors for depression—among low-income, urban African American girls. They suggested that African American culture emphasizes women's competence, versatility, and connectedness with family and community, which shape a different conception of femininity from the one in mainstream White middle-class culture.

Another critique concerns the inconsistent association between feminine personality traits and psychological outcomes, suggesting the need to examine other moderating or mediating variables. For instance, while research found that high femininity predicted lower depression in the event of high interpersonal stress, and high masculinity predicted lower suicidal ideation in situations with high-achievement stress, the effect of gender orientation was dependent on participants' biological sex—high femininity was more of a protective factor for women as was high masculinity for men (Waelde et al., 1994). In a study conducted with more than 900 working men and women in Japan, Mori et al. (2002) also found that gender personality traits interacted with biological sex in influencing participants' mental health. High masculinity was related to poor mental health in women, whereas high femininity was associated with poor mental health in men. Japanese women and men who do not fulfill traditional cultural expectations of gender roles (e.g., being feminine for women and being masculine for men) might experience more societal and familial pressure and hence suffer from poorer mental health.

Finally, personal values could have a significant influence on how gender roles influence psychological well-being. Grimmell and Stern (1992) argued that it was the discrepancy between a person's ideal personality traits and his/her actual personality traits—not the gender personality traits per se—that predicts psychological health. In their study, Grimmell and Stern found that both men and women had an ideal that was significantly more masculine than they themselves were, and neither sex endorsed an ideal person who was more feminine than self, reflecting a personal valuation of masculinity traits. Further, the closer one's actual rating of masculinity was to one's ideal masculinity, the higher self-esteem and the lower anxiety and depression one would report. The personal valuation of masculinity traits may reflect the inherent male bias in theories of psychological development, equating maturity and successful adjustment with such masculine traits as independence, rationality, achievement, and action. By contrast, feminine attributes—warmth, compassion, emotional expressiveness, concerns for others' needs—that emphasize relationship rather than achievement, are seen as expressions of inferiority and receive less respect and status than masculine traits. Again, not all women adhere to their feminine- or masculine-ideal traits, and certainly not in a homogenous or ubiquitous manner. The next two sections discuss how societal and cultural forces shape women's gender experiences and expectations, as well as how women actively attempt to construct their subjective meaning of femininity.

GENDER-ROLE SOCIALIZATION PERSPECTIVE

Theories that emphasize the gender-role socialization perspective on femininity focus on the role of social influences on women's lives (Bronstein, 2006; Chrisler, 2008). To best understand the gender-role socialization perspective, a distinction needs to be made between sex roles and gender roles. Sex roles are behaviors related to one's biology (e.g., reproductive functions), whereas gender roles are behaviors women and men enact based on socially constructed notions of femininity and masculinity (Pleck, 1981, 1995). Hence, women's gender roles are not biologically based, but are constructed by social forces concerning what constitutes femininity. Through the process of gender-role socialization, girls and women internalize societal expectations of what are prevalent and acceptable feminine behavior and attitudes. This process of socialization takes place through basic social-learning processes, such as modeling, rewards, and punishments (Addis & Cohane, 2005). Additionally, the learning process includes direct verbal transmissions of gender-role messages (e.g., mothers telling their daughters that it is unladylike to swear) as well as indirect messages (e.g., observing that one's parents engage in gender-stereotypic occupations) (Bronstein, 2006). Sociocultural models of eating disorders offer one of the best illustrations of how gender-role socialization affects women's mental health. Girls and women's exposure to Western culture's idealization of female extreme thinness and the objectification of the female body lead to the internalization of these ideals, which results in a discrepancy between their current and ideal body image, which in turns engenders

body dissatisfaction and disordered eating patterns (Fredrickson & Roberts, 1997; Striegel-Moore & Bulik, 2007).

Although there are several variations of the gender-role socialization perspective, the Gender Role Strain Paradigm (Pleck, 1981, 1995) has emerged as a useful approach to understanding how gender-role socialization becomes a source of stress for women. Originally developed by Pleck (1981) to explain men's experiences of gender-related strain, the Gender Role Strain Paradigm has also been applied to women (Levant & Philpot, 2002). The Gender Role Strain Paradigm suggests that gender roles are not only socially constructed, but also are problematic and patriarchal (Levant & Philpot, 2002). Brooks and Good (2001) summarized several important assumptions about this viewpoint: (a) gender-role norms are often inconsistent and contradictory, (b) gender-role norms are frequently violated; (c) social condemnation and stressful psychological consequences commonly follow role violations, and (d) many behaviors prescribed by gender-role norms are psychologically dysfunctional. Pleck (1995) proposed that the influence of gender roles on people results in gender-role strain. Three forms of gender-role strain have been identified (Levant & Philpot, 2002; Pleck, 1995): (a) discrepancy strain occurs when women do not live up to their internalized gender ideals (e.g., "I believe women's main role is to stay at home to care for their children, but I chose to work full-time."); (b) dysfunctional strain occurs when women adhere to traditional gender roles because they often have deleterious consequences for themselves and their loved ones; and (c) trauma strain that occurs from the process of gender-role socialization is experienced as traumatic (e.g., women's experience of sexual and physical abuse by men).

The main focus of recent empirical research on women's gender-role socialization has been on the second form of gender-role strain—dysfunctional strain; that is, the strain that occurs when women attempt to fulfill traditional gender roles. What follows is a review of three related but relatively distinct approaches that delineate the link between women's adherence to gender roles and their psychological well-being: (a) femininity ideology, (b) conformity to feminine norms, and (c) feminine gender-role stress.

Femininity Ideology

Feminist ideology refers to girls and women's internalization of cultural beliefs about their gender roles (Levant, Richmond, Cook, House, & Aupont, 2007; Tolman & Porche, 2000). Consistent with Pleck's (1981) Gender Role Strain Paradigm, femininity ideology has been conceptualized as inherently patriarchal and oppressive for girls and women (Bartky, 1990; Tolman & Porche, 2000). Research in this area has been advanced through the use of two main measures of femininity ideology—the Adolescent Femininity Ideology Scale (AFIS) (Tolman and Porche, 2000) and the Femininity Ideology Scale (FIS) (Lehman, 2000; Levant et al., 2007). Both measure ideology based on the dominant White middle-class notions of femininity.

The AFIS measures two dimensions of femininity ideology that represent internalized forms of oppression relevant to adolescent girls—inauthenticity in relationships and body objectification. Tolman and colleagues (2006) argued that girls' internalization of these two dimensions of femininity ideology might account for higher rates of mental health problems among girls as compared to boys. Inauthenticity in relationships is grounded in the notion that as girls enter adolescence, they lose their ability to be authentic about their feelings and thoughts, and they hide their true selves to please others and avoid relationship conflicts (Brown & Gilligan, 1992). Brown and Gilligan have proposed that being authentic in relationships is an important component of psychological health; therefore, inauthenticity in relationships may undermine one's well-being. Consistent with this notion, studies using the AFIS have shown that inauthenticity in relationships was associated with lower levels of self-esteem, increased levels of depression, feeling pressure to have or retain a boyfriend, poorer sexual self-efficacy and sexual health, a more negative first coital experience, and poorer body image in adolescent girls and young adult women (Impett, Schooler, & Tolman, 2006; Impett, Sorsoli, Schooler, Henson, & Tolman, 2008; Smiler, Ward, Caruthers, & Merriwether, 2005; Theran, 2010; Tolman, Impett, Tracy, & Michael, 2006; Tolman & Porche, 2000).

The second dimension of femininity ideology proposed by Tolman and Porche (2000) is body objectification, which reflects adolescent girls' view of their bodies as objects and their imposition of impossible standards of thinness on themselves (Bartky, 1990). Studies using the AFIS have demonstrated that body objectification was associated with lower self-esteem, increased levels of depression, poorer sexual self-efficacy, and lower levels of sexual health among adolescent girls (Impett et al., 2006; Tolman et al., 2006; Tolman & Porche, 2000).

One limitation of the AFIS is that it only measures two dimensions of femininity ideology. In contrast, the FIS for adult women consists of five dimensions of femininity ideology (Lehman, 2000; Levant et al., 2007). These dimensions include: (a) stereotypic images and activities, the notion that women should maintain an image and physical appearance that is in line with stereotypical notions of the ideal woman; (b) dependence/deference, which reflects the idea that women should play deferent and dependent roles in their relations with their romantic partners; (c) purity, which reflects women's chastity and the passive sexual roles women should play; (d) caretaking, which prizes motherhood as the ultimate fulfillment for women; and (e) emotionality, the notion that women are expected to be emotional and engage in domestic work. Published research on the relationship between femininity ideology as measured by the FIS and women's well-being is still in its infancy. One recent study of undergraduate women found that adherence to the femininity ideology of stereotypic images and activities was negatively associated with appreciation of one's own body (Swami & Abbasnejad, 2010).

Feminine Gender-Role Stress

Eisler and colleagues (Eisler, 1995; Eisler & Skidmore, 1987; Gillespie & Eisler, 1992) argued that masculine or feminine personality traits per se do not

predict vulnerability to psychological problems. Instead, it is the rigid commitment and adherence to culturally prescribed models of masculinity and femininity that interferes with one's objective evaluation of a situation and leads to a limited repertoire of coping skills. As a result, a person with rigid commitment is likely to experience increased levels of stress when she or he engages in behaviors that deviate from traditional gender-role expectations.

To measure men and women's cognitive tendency to appraise specific behaviors or situations as stressful as a result of their rigid adherence to traditional gender roles, Eisler and colleagues developed the Masculine Gender Role Stress Scale (MGRS) (Eisler & Skidmore, 1987) and the Feminine Gender Role Stress Scale (FGRS) (Gillespie & Eisler, 1992). The constructs of MGRS and FGRS differ from ones that measure personality traits (e.g., BSRI, PAQ) in that: (a) the former measure a person's cognitive appraisal of situations that are role dystonic, whereas the latter measure a person's self-perceptions of socially desirable personality attributes for men and women; (b) the former assess negative aspects of gender roles, whereas the latter focus on the positive aspects of gender roles. Specifically, FGRS assesses five fears or stressors for women: (1) fear of developing an unemotional relationship; (2) fear of being physically unattractive; (3) fear of being victimized or exposed to potential harm or violence; (4) fear of behaving assertively; and (5) fear of not being sufficiently nurturant. For instance, the situation of "having someone else to raise your children" may elicit stress for women who perceive that they have failed to live up to the feminine role expectation of caretaking (i.e., fear of not being sufficiently nurturant).

Research studies generally support the notion that feminine gender-role stress is related to psychological health problems, such as depressive symptoms, eating disorders, and somatization (e.g., Gillespie & Eisler, 1992; Martz et al., 1995; Mussap, 2007). Martz and colleagues (1995) found that young women hospitalized with an eating disorder—compared to women hospitalized with other psychiatric disorders or normal controls—reported elevated scores of stress on the overall FGRS scale and four of its subscales: fear of unemotional relationship, fear of physical unattractiveness, fear of victimization, and fear of behaving assertively. While fear of physical unattractiveness clearly poses risk for developing eating disorders, the other three factors may underlie behaviors associated with eating disorders. Fear of victimization, unemotional relationship, and behaving assertively may lead to women's tendency to yield to others' needs, a reduced repertoire of coping skills, diminished senses of self, feelings of inadequacy in various situations, and maladaptive coping through dieting, binging, and purging.

Mussap (2007) reported that feminine gender-role stress may be linked with specific eating disorder symptoms—for instance, fear of unattractiveness was associated with dietary restraint, binge eating, purging, and eating concern, whereas fear of behaving assertively was correlated with eating concern. Mussap also found that these relationships are partially accounted for by psychological variables, such as overcontrol and body dissatisfaction, suggesting an indirect pathway. In other words, adherence to rigid feminine gender roles not only plays a direct role in disordered eating but may also shape one's orientation toward

perfectionism, tendency to control through self-denial, and internalization of the culturally sanctioned thin ideal, which leads to eating disorder symptoms.

Despite evidence that feminine gender-role stress is positively correlated with psychopathology, researchers (e.g., Bekker & Boselie, 2002; Martz et al., 1995; Mussap, 2007) have cautioned against any interpretations made about causality. It remains unclear whether FGRS precedes psychopathology or conditions of psychopathology precede FGRS. Moreover, Bekker and Boselie found that stress in general, rather than feminine gender-role stress, may be relevant to the development and maintenance of eating disorders. In their studies, women with bulimic disorders reported not only higher levels of feminine gender-role stress, but also higher levels of masculine gender-role stress and general stress when compared to women who had never been diagnosed with eating disorders. After controlling for general stress, the difference in feminine gender-role stress between women with bulimic disorder and those without disappeared. General stress, nevertheless, remained a significant predictor of eating disorder behavior.

Conformity to Feminine Norms

Mahalik and colleagues (2003; 2005) posited that individuals vary in their degree of adherence to their gender-role norms, depending on the influences of their distinct sociocultural injunctions, cognitions, and emotions. For instance, one woman may deem “being domestic” as the most salient aspect of her feminine gender norms, whereas another woman may consider “sexual fidelity” as the most salient norm. To measure variability in the gender-role salience between individuals, Mahalik and colleagues developed the Conformity to Masculine Norms Inventory (CMNI) and the Conformity to Feminine Norms Inventory (CFNI). The CFNI is an 84-item self report that focuses on dominant European American, middle- and upper-class heterosexual construals of feminine norms. The authors argued that these dominant feminine norms permeate U.S. society and are likely to affect all women in that society, including those from diverse ethnic-cultural groups. The CFNI constitutes the following eight norms: (a) Nice in Relationships, (b) Thinness, (c) Modesty, (d) Domestic, (e) Care for Children, (f) Romantic Relationship, (g) Sexual Fidelity, and (h) Invest in Appearance.

Conformity to feminine norms has been implicated in women's psychological well-being. Appearance-related norms of femininity such as “Thinness” and “Invest in Appearance,” and non-appearance-related feminine norms such as “Modesty” and “Romantic Relationship” were predictive of body image and eating concerns (Mahalik et al., 2005), depression, eating-disorder symptoms, and lower self-esteem (Hurt et al., 2007). Hurt et al. further suggested that conformity to feminine norms mediates the association between feminist identity and psychological outcomes. Put in another way, a low feminist identity was related to endorsing feminine norms of “Thinness,” “Invest in Appearance,” and “Romantic Relationship,” which in turn led to negative psychological outcomes.

On the other hand, Mahalik et al. (2005) found that certain features of femininity, such as "Nice in Relationships" and "Care for Children," were associated with fewer eating and body concerns, thereby acting as a buffer against eating disorders. All in all, these findings suggest that factors in CFNI may differentially predict clinical outcomes and may be directly or indirectly related to psychopathology. The interactions among feminine norms, self-identity, and other potential variables, such as self-efficacy and coping responses, are complex (see discussion in Mahalik et al., 2003) and warrant further investigation.

Critiques of the Gender-Role Socialization Perspective

Several potential limitations of the gender-role socialization approaches should be noted. Gender-role socialization theories have been tested mainly with White women and girls and tend to be based on Western heterosexual femininity norms (e.g., Mahalik et al., 2005). There is insufficient research and theorizing on how gender-role socialization applies to nonheterosexual and racial/ethnic minority women. For instance, we do not know whether the femininity norms identified in the CFNI (Mahalik et al., 2005) are as relevant to women of color as they are to White women. Additionally, the items in current femininity measures based on the gender-role socialization perspective tend to be generically worded rather than situation or domain specific (e.g., "A woman should not be competitive"; Levant et al., 2007). Accordingly, femininity is implicitly treated as a collection of stable, trait-like attributes in such measures. What is lacking in these measures is an assessment of how women's experience of femininity varies across life domain and situation. For instance, a woman might believe that one should not be competitive with other family members but nevertheless embraces competitiveness in the workplace.

SOCIAL CONSTRUCTIONIST PERSPECTIVE

Social constructionist approaches to femininity align with the gender-role socialization perspective in their emphasis on the role of social influences on women's and men's gendered behavior (Addis & Cohane, 2005). However, social constructionist approaches emphasize that individuals play an active role in constructing meanings of gender in specific social situations rather than simply being passive recipients of social influences (Wong & Rochlen, 2008). Femininity does not represent an internal core of a woman but is viewed as a practice that is constantly performed in specific situations (Paechter, 2007). Accordingly, there are multiple versions of femininity or femininities that vary across cultural groups and situations (Schippers, 2007).

Guided by social constructionist perspectives, we recently proposed the Subjective Gender Experiences Model as a new theoretical model to understand women's and men's experiences of gender (Shea et al., 2010; Wong et al., 2010). According to this model, the use of language is the most conspicuous way in which women and men construct meanings of gender. We refer to this process as genderization. When genderization takes place at the personally relevant,

experiential level (e.g., “As a woman, I find it hard to succeed in a man’s world”), we refer to this process as subjective gender experiences. Although subjective gender experiences are applicable to both women and men, we use the narrower term—subjective femininity experiences—when referring to a woman’s subjective experiences of what it means to be a woman. In line with social constructionist viewpoints on femininity (Paechter, 2007), subjective femininity experiences are diverse, idiosyncratic experiences that vary depending on women’s social context, cognitions, and emotions (feeling sad versus feeling happy). Moreover, unlike the gender-role socialization perspective, the dimensions of subjective feminine experiences do not simply reflect the dominant White, middle-class femininity norms, but also reflect a broader range of femininities that may be relevant to women from minority groups (e.g., African American women).

In contrast to the Gender Role Strain Paradigm (Pleck, 1981; 1995), our model does not assume that the dimensions of subjective femininity experiences are inherently dysfunctional. Indeed, it is possible that some dimensions of subjective femininity experiences may be positively associated with women’s well-being, whereas other dimensions are negatively associated with well-being. Additionally, we also propose that women’s appraisal of their subjective femininity experiences are idiosyncratic and diverse. It is possible that some women might perceive a particular dimension of subjective femininity experience (e.g., emotional expressiveness) as stressful, whereas others do not. Guided by the stress and coping literature (Lazarus & Folkman, 1984), we theorize that the stress associated with subjective femininity experiences refers to women’s cognitive appraisal of specific subjective femininity experiences as stressful. Women experience stress associated with subjective femininity experiences when they perceive they have difficulty coping with societal-imposed or internalized notions of what it means to be a woman. Given the centrality of gender in women’s lives, stress related to subjective femininity experiences is theorized to increase women’s risk of experiencing psychological distress.

To operationalize the key constructs in the Subjective Gender Experiences Model, we developed the Inventory of Subjective Masculinity Experiences (ISME; Wong et al., 2010) and the Inventory of Subjective Femininity Experiences Inventory (ISFE; Shea et al., 2010). The ISFE—a measure of women’s subjective femininity experiences—includes the Subjective Femininity Stress Scale (SFSS). The SFSS assesses stress associated with women’s subjective femininity experiences. In the following section, we describe preliminary findings on the link between women’s subjective femininity experiences and their psychological well-being based on the SFSS.

Subjective Femininity Stress Scale Preliminary Results

We invited about 600 female participants to complete the sentence, “As a woman ...” 10 times, after which the participants indicated the frequency with which each of the 10 experiences was stressful on a five-point scale. The overall score of the SFSS was determined by averaging responses across the 10 stress

responses. Our participants were from ethnically diverse backgrounds, and the majority of them were college students (Shea et al., 2010).

We found evidence for the internal consistency, test-retest reliability, convergent, divergent, and concurrent validity of the SFSS (Shea et al., 2010). Our findings also suggested that increased subjective femininity stress was associated with higher levels of depression, psychological distress, disordered eating attitudes, and lower levels of satisfaction with life and self-esteem.

The ISFE captures multiple dimensions of subjective femininity experiences (e.g., body image, competence) based on participants' qualitative responses to the 10 "As a woman ..." prompts (e.g., "As a woman, I am always concerned about how I look"; "As a woman, I am self-reliant and strong"). Scores for each dimension range from 0 to 10. For instance, a participant who provided descriptions associated with body concerns in 3 of her 10 responses received a score of 3 in the body-image dimension of the ISFE. We are currently in the process of examining the relationship between the dimensions of femininity and the outcomes of psychological well-being (e.g., eating attitudes, self-esteem, satisfaction with life).

Implications for Research

Research on the ISFE and SFSS is still in its infancy. Future research should investigate whether the ISFE dimensions and SFSS are associated with other outcomes of well-being, such as interpersonal health, physical health, and health behaviors. In addition, it would be important to identify mediators that might explain the mechanisms through which subjective femininity experiences influence women's psychological well-being, as well as moderators of this relationship. In line with social psychological experiments that use priming techniques (e.g., Dalsky, 2010), the ISFE can be used to prime women with femininity concepts to investigate the influence of subjective femininity experiences on women's well-being. For instance, by randomly assigning women to complete the ISFE versus a control group, researchers can test whether a focus on subjective femininity experiences influences women's affective states (e.g., higher levels of negative emotions).

Implications for Practice

In the last few decades, there have been rapid changes in educational levels and in work and family roles for women (Bond, Galinsky, & Swanberg, 1998). The changing landscape has had a profound impact on women's family life, relationships with men (both at home and at work), and psychological well-being (Barnette & Hyde, 2001). Scholars have advocated for a gender-informed therapeutic approach, which encourages practitioners to become aware of the differences in attitudes, behaviors, and beliefs in their clients, as well as the differences in power status, social position, and privilege in society due to the gender-socialization experiences and expectations (Hare-Mustin, 1987; McGoldrick, Anderson, & Walsh, 1989).

The ISFE and SFSS can potentially be used as tools by clinicians, therapists, and counselors to examine their female clients' subjective, idiosyncratic, and

personal experiences regarding what it means to be a woman. The open-ended nature of the ISFE allows clients to generate and elaborate on personally relevant gender experiences, rather than responding to survey questionnaires with predetermined dimensions of femininity. Additionally, the SFSS enables clients to identify and discuss the types of subjective femininity experiences that could be potential sources of stress and distress (i.e., a high stress-frequency rating) or sources of resilience and strength (i.e., a low stress-frequency rating). Using the clients' responses to the SFSS, clinicians and clients could enter a dialogue about the impact of subjective femininity experiences on ones' behaviors, attitudes, and psychological health; understand and challenge the dominant discourse of gender roles and expectations; and modify clients' self-limiting beliefs and thinking.

SUMMARY AND CONCLUSION

In this chapter, we reviewed three distinct but related theoretical perspectives on femininity and their implications for women's psychological well-being: (a) personality traits perspective; (b) gender-role socialization perspective; and (c) social constructionist perspective.

We discussed critiques of personality traits and gender-role socialization perspectives, as well as explored how social constructionist perspectives could inform research and clinical work that embrace the diversity of women's voices and examine the multiple realities of femininity.

Future studies on women's psychological health should consider examining the experiences of gender beyond biological sex, as women vary in their identification and adherence to feminine traits, gender roles, and expectations. Second, research should explore the role of other mediating and moderating variables (e.g., situational stressors, cognitions) to provide a more nuanced understanding of the relationship between femininity and women's psychological well-being. Third, relations between femininity and psychological health are not context-free. The concepts of femininity and gender roles may have different meanings to members of diverse socioeconomic, racial-ethnic, and cultural groups. Research should capture how these concepts are defined, understood, and expressed in participants' sociocultural context. The applicability of previously developed measures of femininity with culturally diverse populations must be carefully considered. Identifying specific sociocultural injunctions that shape women's gender experiences and discourse will allow researchers and practitioners to develop and implement gender-sensitive and culturally appropriate preventative strategies and interventions with women from diverse backgrounds.

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Chapter 3

A Review of Recent Research on Multiple Roles and Women's Mental Health

Yessenia Castro and Kathryn H. Gordon

It has become increasingly common for women to balance multiple social roles (Barnett & Hyde, 2001). For example, there has been substantial growth in the number of women who count the role of paid worker among their social roles. In the United States, the number of women ages 25 to 64 who participate in the labor force has approximately tripled from 1970 to 2008, so that the majority of women currently participate in the labor force (U.S. Bureau of Labor Statistics, 2009). Among employed women, 62% work full-time, year-round jobs, and 5.6% have more than one job (U.S. Bureau of Labor Statistics, 2009). Women are also now more likely to be found in higher-level positions in their occupations than in any other time in the past, and the proportion of working women with college degrees has tripled since 1970 (U.S. Bureau of Labor Statistics, 2009).

In addition to taking on the role of paid worker, women frequently occupy multiple additional roles, including being a spouse, a parent, and/or a caregiver to a disabled or ill adult. With regard to the spouse role, the husband is rarely the only wage earner in the household anymore, as this type of situation has decreased by half in the past 40 years, from 36% in 1967 to 18% in 2007 (U.S.

Bureau of Labor Statistics, 2009). Moreover, working wives are now responsible for an average of 36% of their family's incomes, and 18% of working wives earn more income than their husbands (U.S. Bureau of Labor Statistics, 2009). Altogether, these data suggest that the household structure is changing in the United States and that women are taking on greater responsibilities with regard to the paid worker role in addition to the spouse role. In addition to being paid workers and spouses, women are also frequently simultaneously occupying the role of parent. The number of women who are both paid workers and parents to children under the age of 18 has increased dramatically in the past three decades (from 47% in 1975 to 71% in 2008), to the point where the majority of mothers are now also employees (U.S. Bureau of Labor Statistics, 2009).

A large proportion of women also take on roles as caregivers to an ill or disabled adult. Approximately 65.7 million people in the United States provide unpaid care for an adult or child with a chronic illness or disabling condition who requires assistance in daily functioning, and women are disproportionately represented in this caregiver role (66% of caregivers are women; National Alliance for Caregiving, 2009). The average age of caregivers is 48, which suggests that most caregivers are also likely to be paid workers, spouses, and/or parents as well. Managing multiple roles in this context can be challenging, given that caregivers spend an average of 20 hours per week doing this type of work, with female caregivers tending to spend more time providing care than male caregivers (National Alliance for Caregiving, 2009). The majority (73%) are employed at some point while acting as a caregiver, and the majority (66%) have had their work affected by their caregiving duties (e.g., arrived late, left early, or took a leave of absence; National Alliance for Caregiving, 2009). Not only are the majority of women in caregiver roles also employees, but a substantial proportion of them also occupy the roles of spouse (63%) and parent or grandparent (37%) with children or grandchildren under the age of 18 in their household (National Alliance for Caregiving, 2009).

Caregiving burdens may affect women more negatively than men with regard to finances because their additional time out of work often leads to lower contributions to pensions and retirement funds (McGuire, Anderson, Talley, & Crews, 2007). Indeed, women who are caregivers are significantly less likely to receive a pension than are male caregivers, and women who do receive a pension receive roughly half of what men do (McGuire et al., 2007). Still, these aspects of the caregiver role must be balanced against the fact that many caregivers also report mental health benefits such as increased sense of meaning, purpose, and other rewards from their contributions.

The understanding of the ways in which multiple social roles affect women is complex, and it is important not to assume that multiple role occupancy necessarily leads to increased stress for women. Rather, it appears to be a more complicated picture for women, in which managing multiple social roles can also come with such benefits as a feeling of belonging and connection to multiple social groups. Accordingly, the American Psychological Association (APA) (2007) has recommended that clinicians make efforts to be aware of the multiple

roles that women occupy, to be sensitive to individual differences with regard to the way women are affected by their multiple roles, and to support and promote empowerment in women.

The APA's (2007) recommendations regarding multiple roles and identities for women reflect a change in modern attitudes toward women and multiple roles. Historically, it was believed that the occupation of multiple roles was detrimental to women, and this belief may have been used as a justification to discourage women from participating in multiple roles. However, as highlighted above, in the past several decades, markedly more women are taking on multiple social roles. Women are substantially more likely to participate in the labor force, to make financial contributions to their families, attain higher education, and occupy greater numbers of leadership roles (Barnett & Hyde, 2001). The structure of families and the lifestyles of women are undeniably changing (e.g., women tend to marry later, have fewer children, and outlive their spouses), and with that, multiple social roles among women are becoming more prevalent (Barnett, 2004). Therefore, the overall influence of multiple social roles on mental health has garnered much scientific attention.

As women increasingly take on multiple social roles, their mental health is likely to be affected in diverse ways that may include both positive and negative effects on risk and protective factors for mental health. Previous theories of women's development have focused on women's roles as mothers and wives as their primary identifications, and these theories tended to be developed without the consideration of societal constraints and environmental influences on gender differences in role occupancy (Barnett & Hyde, 2001). More recent viewpoints on the impact of multiple roles on mental health have been developed to include the additional roles that women today occupy. For instance, role accumulation theory (Seiber, 1974) or role enhancement theory (Marks, 1977) posit that multiple roles are beneficial for mental health because they increase feelings of belonging and purpose and of self-efficacy, as well as increased opportunities for success, social support, and greater emotional and economic resources, among other things (Barnett & Hyde, 2001; Seiber, 1974). The role enhancement perspective also suggests that multiple roles would lead to greater mental health for women because success and rewards in some roles may buffer them from stress occurring in one or more other roles (Barnett & Hyde, 2001; Reid & Hardy, 1999). This theory refutes the role strain theory (Goode, 1960; Marks, 1977), which posits that multiple roles are detrimental for mental health because they exhaust the limited psychological, physical, and inter/intrapersonal resources of the persons occupying multiple roles. The role strain perspective suggests that occupying multiple roles would increase tension for women by absorbing their time and energy, which would consequently lead to less time and energy for seeking support and for nurturing relationships, and in turn lead to worsened mental health (Reid & Hardy, 1999). In fact, although there are situations in which multiple role occupancy can negatively affect mental health, the preponderance of data supports the role enhancement hypothesis over the role strain hypothesis (Barnett, 2004).

Current research and theory are bringing increased attention to the importance of the idea that the effects (whether positive or negative) of multiple social role occupation are not a direct function of mere role occupation, but are actually a function of one's experiences within the roles, and the effects of those experiences on the inter- and intrapersonal risk and protective factors associated with mental health outcomes, such as stress, self-esteem, mastery, or self-efficacy.

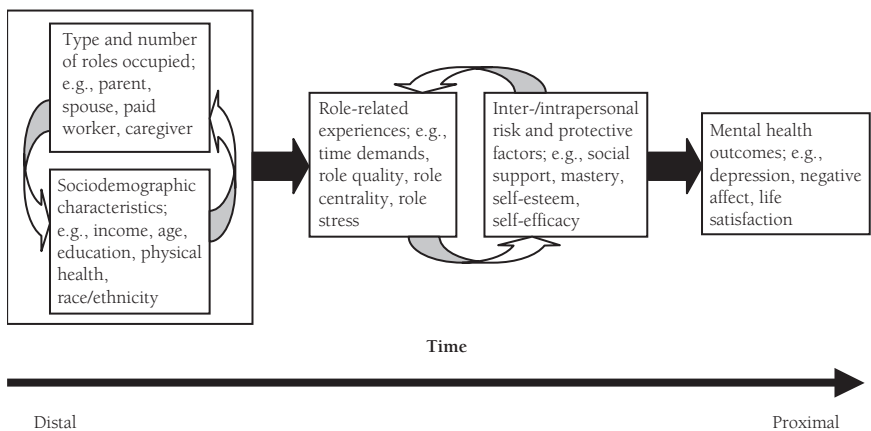
THE CONCEPTUAL FRAMEWORK

The goal of this chapter is to summarize recent research examining the mechanisms linking multiple roles to mental health and well-being, as well as to describe the variables that moderate this effect. This review is organized in accordance with the conceptual framework presented in Figure 3.1, which was constructed to reflect theory and research on the relationship between multiple roles and women's mental health. Mental health and well-being was defined broadly, thus a number of mental health outcomes were considered. These included depression, positive affect, negative affect, life satisfaction, psychological distress, and others, so long as those outcomes are operationalized through means that are reasonably psychometrically sound. Our goals were to provide the reader with an empirically informed conceptual and organizational framework of the determinants of mental health among women who balance multiple social roles that can inform future mental health research as well as to identify gaps in the extant literature.

Figure 3.1 illustrates that sociodemographic variables and number of social roles occupied mutually influence each other. For example, research has demonstrated that age and health status exert a negative influence on number of social roles

Figure 3.1.

An organizational framework for studying the relationship between multiple roles and women's mental health.



occupied, but occupation of certain social roles may affect other demographic variables, such as income (e.g., occupation of the partner role or paid worked roles likely affect income). Social roles and demographic characteristics directly influence a number of positive and negative experiences inherent in occupying multiple roles (i.e., role-related experiences). For example, according to the theory of role strain, occupation of multiple social roles may lead to increased time demands or conflicts among responsibilities of each role. In contrast, role enhancement theory would predict that, as a result of occupying multiple roles, one would enjoy increased opportunities for rewarding experiences.

As depicted in Figure 3.1, role-related experiences in turn affect many inter- and intrapersonal risk and protective factors of mental health outcomes. For example, a woman who experiences many rewards in one or more social roles may report higher levels of self-efficacy or self-confidence compared to a woman who experiences few or no rewards. Additionally, inter-/intrapersonal variables may reciprocally affect role-related experiences to mitigate or exacerbate their occurrence or their effects on other inter-/intrapersonal factors. For example, a woman with low levels of social support may be less able to manage the demands of multiple roles compared to a woman with high levels of social support. Consequently, the woman with low social support may be more susceptible to role strain and experience lower levels of self-efficacy. Thus, role-related experiences and inter-/intrapersonal factors may mutually influence each other, and in time these variables influence psychological well-being in the form of life satisfaction, depression, and other mental health outcomes. What follows is a review of the recent literature examining each aspect of the organizational framework depicted in Figure 3.1.

MULTIPLE ROLES AND WOMEN'S MENTAL HEALTH

Research consistently demonstrates a relationship between occupation of multiple social roles and a variety of indicators of mental health. For example, in a community sample of older adults, Adelman (1994) found that the number of social roles occupied was positively related to life satisfaction and self-efficacy, and negatively related to depression among both men and women. Hong and Seltzer (1995) found that this was true even among women who had held a particularly unique and difficult role for a substantial amount of time, that of being a mother to a mentally retarded adult child. In this study, occupation of more social roles was negatively associated with depression symptoms among mothers. Specifically, women who held only one other social role in addition to that of mother to a mentally retarded adult reported higher levels of depression compared to mothers who occupied two or three additional roles. Hong and Seltzer's study is also one of the few studies that prospectively examined the relationship between number of social roles and mental health. They found that changes in number of social roles over 18 months significantly predicted depression at the end of that period. Thus, Hong and Seltzer could argue with some degree of confidence that

the number of social roles occupied by the women exerted a causal effect on their mental health. Although these are only two examples, ample research has demonstrated a positive relationship between occupation of multiple social roles and psychological well-being (Cochran, Brown, & McGregor, 1999; Dautzenberg, Diederiks, Philipsen, & Tan, 1999; Kopp & Ruzicka, 1993; Kuntsche, Knibbe, & Gmel, 2009; Lahelma, Arber, Kivela, & Roos, 2002; Thiots, 1983; Wethington & Kessler, 1989).

SOCIODEMOGRAPHIC VARIABLES RELATED TO OCCUPATION OF MULTIPLE ROLES

A number of sociodemographic variables have been found to be associated with occupation of multiple social roles. Evandrou and colleagues (2002) examined the relationships among three social roles (caregiver to a disabled adult, paid worker, and parent) and demographic variables in a nationally representative sample of men and women in Britain. They found that gender, age, physical health status, and marital status were all related to multiple role occupancy. According to Evandrou et al.'s findings, gender appears to influence the type of role combinations that individuals are likely to possess. While men and women in this study were equally likely to possess multiple social roles, men were more likely to possess multiple roles where paid worker accounted for one role, whereas women were more likely to possess role combinations where caretaker to another adult accounted for one role. Additionally, older age, poor health, and being single were all associated with holding fewer social roles. Age was posited to have a direct negative effect on occupation of multiple roles because as individuals age they are more likely to experience a number of events related to loss of a role, for example, children leaving home (loss of the parent role), retirement (loss of the paid worker role), and divorce or death of the partner (loss of the spouse role). Poor health likely imposes a variety of physical limitations that hinders participation in multiple roles. Although marital status in itself constitutes a social role, it likely affects occupation of the parent role.

Similar to Evandrou et al. (2002), Adelman (1994) found that multiple role occupancy was negatively correlated with age and problematic health. In contrast to Evandrou et al., Adelman found that men were more likely to hold multiple roles compared to women. Additionally, Adelman reported positive correlations between multiple role occupancy and educational attainment, and being White (versus African American). These additional findings may be accounted for by the many additional social roles that were assessed by Adelman. In addition to the roles of caregiver, paid worker, and parent, they included volunteer, student, grandparent, spouse, and homemaker when assessing multiple role occupancy.

Thus, the extant literature suggests that a variety of demographic variables are related to multiple role occupation. Relationships with some demographic variables, such as age and health status, appear to be more clear than others, such as gender or race. Further, although research suggests that race and gender may

affect occupation in multiple roles, it additionally suggests that these demographic variables may differently affect occupation of specific social roles. However, these latter conclusions are based on very few studies, and more research is needed that both further demonstrates these relationships and attempts to understand the source of these race and gender differences. Additionally, research on multiple roles in more diverse samples and studies that examine racial/ethnic minorities and other special populations of women in their own right, versus comparatively to the majority group, appear to be lacking, although there are a few exceptions (e.g., Cochran et al., 1999; Rao, Apte, & Subbakrishna, 2003; Tang, Lee, Tang, Cheung, & Chan, 2002; Wallace Williams, Dilworth-Anderson, & Goodwin, 2003).

ROLE-RELATED EXPERIENCES

Given long-standing research that has consistently demonstrated a relationship between multiple role occupancy and mental health among women, much research has turned toward understanding the processes by which occupation of multiple roles impacts mental health. An area of prime interest has been the kinds of experiences that a woman encounters in each of her roles. These role-related experiences are not only hypothesized to be mechanisms through which multiple role occupancy exerts its effect on mental health, but may also serve to mitigate or exacerbate the effect of other variables on mental health among women occupying multiple social roles. Some of the role-related experiences that stand out in the current literature are detailed below.

ROLE TIME DEMANDS

Research on the amount of time spent occupying social roles and women's mental health is complex but suggests a significant relationship. The role strain hypothesis would predict that increased time spent attending to the responsibilities of different social roles would have a detrimental effect on women's mental health by putting strains on the limited amount of time they have to attend to their social roles, while the role enhancement hypothesis would predict a positive effect on well-being by allowing for more time within each role for positive experiences. In fact, extant research demonstrates support for both positive and negative effects of time spent in social roles. McCullough and Zick (1992) found that more time spent in the paid worker and homemaker roles was significantly related to higher reports of life satisfaction in a large sample of women engaged in various combinations of the paid worker, homemaker, parent, and spouse roles. Further, this relationship remained significant even after controlling for sociodemographic variables and role strains. However, Reid and Hardy (1999) found positive relationships between depression and time spent in the paid worker role, as well as a positive relationship between depression and time spent in the caregiver role. Together, these findings suggest that increased time in social roles (paid worker, homemaker, caregiver) can have

both positive and negative effects on well-being, although the mediating variables that determine a positive or negative trajectory have not been identified.

However, Martire, Stephens, and Atienza (1997) demonstrated a notable moderating effect of time spent in the paid worker role that was consistent with the role enhancement hypothesis. In a sample of 118 women who were caregivers to a disabled parent and employed at least 10 hours per week, time spent in the paid worker role appeared to mitigate the effects of stress in the caregiver role on mental health. Among women who worked part time, caregiver stress was associated with mental health, whereas this association was not significant for women who worked full time. Thus, more time spent working protected women from the negative effects of caregiver stress on their mental health.

ROLE STRESS

The negative effect of stress on mental health is well established, and the stress across multiple roles is no exception. Glynn, Maclean, Forte, & Cohen (2009) examined stress across multiple roles for its effect on mental health in a representative sample of Canadian women and found that role stress was the stronger predictor of mental health compared to demographic variables and role quality in four domains. As would be expected, greater role stress was associated with poor mental health. However, Glynn et al. used a global measure of role stress and could not address the question of how stress in specific social roles influenced well-being. Martire, Stephens, and Townsend (2000) demonstrated that role-specific stresses can affect psychological well-being. In their study of 296 women occupying four social roles, stress in the role of caregiver to another adult significantly predicted greater depressive symptoms, and stress in the parent role was significantly related to lower life satisfaction. Stress in the paid worker role predicted greater depression, and stress in the spouse role predicted lower life satisfaction and greater depression.

Franks and Stephens (1992) further found support for the idea that stress in a specific role can contribute uniquely (i.e., above and beyond stress in other roles) to well-being in a sample of women holding multiple roles (caregiver to an adult family member, parent, and spouse). In a sample of 106 caregivers, stress experienced in the roles of caregiver and parent significantly and uniquely contributed to the prediction of self-reported positive and negative affect. (But stress in the role of wife did not contribute to the prediction of positive or negative affect above and beyond caregiver and mother stresses.) In a follow-up study (Stephens, Franks, & Townsend, 1994), the authors found that role-specific stress was predictive of positive and negative affect after additionally controlling for perceived role rewards. In a small sample of mothers from dual-earner couples, Schwartzberg and Dytell (1996) found that work stress and family stress significantly and uniquely predicted depression. Thus, role stress not only has a consistent negative effect on women's well-being, but stress in specific roles appears to independently influence

well-being, and those effects remain even after accounting for demographics and other role-related variables.

ROLE QUALITY

Research on role quality was among the first research in response to the need for better understanding of the processes through which multiple role occupancy affects mental health and has been argued to be a key mechanism of the relationship between multiple roles and well-being (Barnett & Baruch, 1985). In line with role enhancement theory, which is concerned in part with the number of opportunities for rewarding experiences within a role as a determinant of well-being, studies of role quality (particularly those of Barnett and colleagues) have often operationalized this construct as an index of rewarding and concerning experiences within a given role. Barnett and Marshall (1992) examined the effects of occupying the parent role, quality of the parent role, and quality of the paid worker role on psychological distress in a sample of employed women. They found that levels of psychological distress did not differ between mothers and nonmothers, but among the mothers, self-reports of low job-role quality and low parent-role quality were significantly associated with greater psychological distress. In another study, Barnett and colleagues (Barnett, Marshall, Raudenbush, & Brennan, 1993) also found that the quality of the paid worker role was significantly associated with greater psychological well-being. Glynn and colleagues (Glynn et al., 2009) found that quality of role in the marital, parental, paid worker, and homemaker domains were all independently associated with better mental health in a population sample of Canadian women.

Franks and Stephens (1992) found that different role-specific stresses uniquely predicted positive and negative affect in a sample of female caregivers to a disabled parent or parent-in-law who additionally held roles of mother and spouse. In a follow-up study with the same sample (Stephens et al., 1994), they simultaneously examined self-report of perceived stress and rewards experienced in each role for their unique effects on positive and negative affect. Unique predictors of positive affect were caregiver stress, mother stress, caregiver rewards, and mother rewards. Thus, perceived rewards were unique predictors of psychological well-being and were significantly predictive above and beyond indicators of role-specific stress.

Like many studies of multiple roles and well-being, these studies examined cross-sectional data and cannot address the alternative explanation that poor psychological health might influence one's perceptions of job role quality. In a relatively rare longitudinal study, Barnett, Marshall, and Singer (1992) examined the relationship between change in quality of the paid worker role and change in psychological distress over a two-year period to address this alternative explanation. The relationship between change in quality of the paid worker role and change in psychological distress over time was significant and negative, but only for single nonmothers. That is, for women who were paid workers but

held no other social role, declines in role quality were related to increase in psychological distress. For women who were paid workers and also held some other role, declines in role quality did not affect psychological distress. Barnett (1994) later found a similar interactive effect on psychological distress for quality of the paid worker and partner roles. In a cross-sectional analysis of data from 300 working women in dual-earner couples, she found that quality of the paid worker and marital roles independently predicted psychological distress. But additionally, high marital quality “buffered” women against the negative effect of poor job role quality on psychological distress.

BUFFERING/SPILLOVER

Data consistently indicate that the quality of a woman's experiences in a social role is an important determinant of her mental health. Interestingly, the data further suggest that the experiences in a given role may actually serve to “buffer” negative experiences in another role. Buffering is a phenomenon whereby positive experiences in one role serve to mitigate the effects of negative experiences in another role, also referred to as a “positive spillover” effect. The phenomenon of “negative spillover,” whereby the negative experiences in one role exacerbate problems or interfere with performance in another role, has also been examined.

Gareis and colleagues (Gareis, Barnett, Ertel, & Berkman, 2009) examined positive and negative spillover from the work role to family roles (work-to-family spillover) and positive and negative spillover from the family roles to the work role (family-to-work spillover) for their effects on a variety of health outcomes, including self-rated health and life satisfaction in a representative sample of U.S. men and women. In the direction of work-to-family, both positive and negative spillover independently predicted self-rated health and life satisfaction. In the direction of family-to-work, positive and negative spillover interacted to predict outcomes. Specifically, positive spillover from family-to-work mitigated the detrimental effects of negative work-to-family spillover on self-rated health and life satisfaction. The authors concluded that positive spillover is a key determinant of the effect of multiple social roles on health because, even when it does not buffer the effect of negative spillover, it has unique effects on health above and beyond those of negative spillover. Grzywacz and Marks (2000a) further illustrated the importance of spillover in this same sample when they found that negative work-to-family spillover was associated with higher odds of problem drinking, and positive family-to-work spillover was associated with lower odds of problem drinking.

Stephens, Franks, and Atienza (1997) examined the relationship between positive spillover and positive affect, and the relationship between negative spillover and depression, in a sample of 105 female paid workers who were also caregivers to a disabled adult. The authors found that positive paid worker-to-caregiver spillover was associated with more positive affect (but there was no association between positive caregiver-to-paid worker spillover and positive affect). Both

negative paid worker-to-caregiver spillover and caregiver-to-paid worker spillover were associated with increases in negative affect. In a sample of 158 employed, married mothers, Tiedje and colleagues (Tiedje et al., 1990) found that the combination of perceptions of low role conflict and high positive spillover was related to low self-report of depression, whereas the combination of low positive spillover and high role conflict was related to high self-report of depression. Finally, Voydanoff and Donnelly (1999) found that negative work-to-home spillover was related to higher depression in a national probability sample of employed women. Further, this effect remained even after accounting for spouse- and child-related sources of stress. Thus, research consistently supports the validity of the concept of spillover and demonstrates the effect of spillover on women's mental health.

ROLE CENTRALITY

Although role centrality can be considered a "role-related variable," it can also be conceptualized as an intrapersonal variable. This is because role centrality refers to the extent to which an individual values a particular role and defines herself in part by that role, and the extent to which a person finds a sense of purpose and meaning in that role (Martire et al., 2000), and so it represents an aspect of self-identity. Role centrality exists for every role occupied and can exist at differing levels in relation to each role. Thus, it can have implications for women's well-being because experiences in roles that are highly central may have more impact on their well-being than experiences in less central roles. Theorists posit that role centrality can have both positive and negative effects on well-being (Krause, 1994; Martire et al., 2000; Thiots, 1992, 1995). On the one hand, accomplishment in a highly central role can lead to greater psychological well-being because this accomplishment has more personal meaning; on the other hand, difficulty or failure in a highly salient role can lead to greater amounts of distress than failure in a less salient role because of the enhanced personal meaning. Additionally, difficulties in less central roles may less strongly influence mental health outcomes compared to difficulties in more central roles.

Martire and colleagues (2000) sought to examine these predictions in a sample of 296 women who each occupied four social roles (parent, spouse, paid worker, and caregiver to another adult). The authors examined the interactive effects of role stress and centrality on depression and life satisfaction. Caregiver centrality was significantly related to life satisfaction, but there was no significant interaction between caregiver stress and centrality in predicting depression or life satisfaction. Centrality of the parent role was related to life satisfaction, and additionally interacted with stress in the parent role to predict depression. Further, centrality of the spouse role interacted with stress in the spouse role to predict life satisfaction. Finally, centrality of the paid worker role predicted depression and life satisfaction, and interaction with stress in the paid worker role predicted depression. Follow-up analyses indicated that parent role stress was more strongly

related to depression among women with low parent role centrality; thus, this interaction was contrary to what role centrality theorists would predict. However, in line with role centrality theory, role stress was more strongly related to psychological well-being among women who reported high levels of centrality of the spouse and paid worker roles. Thus, Martire and colleagues found some support for the hypothesized relationship between role centrality and psychological well-being. The difficulty in finding consistent effects of role centrality by Martire et al. may be explained in part by research by Norton and colleagues (Norton, Stephens, Martire, Townsend, & Gupta, 2002). In a sample of 182 midlife women occupying multiple roles (caregiver to another adult, parent, spouse, and paid worker), Norton and colleagues found that centrality of roles changed over time and circumstances. When stress increased in the spouse or paid worker roles, the centrality of these roles decreased. Meanwhile, when rewards increased in caregiver, mother, spouse, or paid worker roles, the centrality of the roles tended to increase. Therefore, Norton et al.'s findings support the idea that role centrality is an important but dynamic variable. It impacts the well-being of women occupying multiple roles but, given this dynamic nature, assessing its influence at one static point in time may not provide a clear picture of its impact.

In sum, research demonstrates that role-related variables appear to be of utmost importance for understanding mental health among women who occupy multiple social roles. Although there is a consistent relationship between number of social roles occupied and mental health, number of roles may merely be a proxy for the many characteristics, costs, and benefits of social roles that actually impact women's mental health.

INTER-INTRAPERSONAL FACTORS

Multiple role occupancy, and the experiences inherent within it, is argued to affect mental health not only through role-role related variables, but also by affecting a number of inter- and intrapersonal variables important to mental health (Barnett, 2004; Barnett & Hyde, 2001; Marks, 1977; Seiber, 1974). Compared to the work conducted on role-related variables, research on inter- and intrapersonal risk and protective factors as mediator of the multiple roles–mental health relationship is limited. However, extant research strongly indicates that these variables are important determinants of mental health among women juggling multiple roles.

SOCIAL SUPPORT

Social support has been found to mitigate the effects of role-related experiences, particularly spillover. Rao and colleagues (Rao et al., 2003) explored a variety of job-related and coping variables for their ability to predict psychological well-being in a sample of 60 working, married mothers in India. Seeking out social support was the strongest predictor of well-being in this sample, which suggests that social support is a key factor in the well-being of women occupying multiple

roles. In a large sample of working, partnered men and women in Malaysia, Md-Sidin and colleagues (Md-Sidin, Sambasivan, & Ismail, 2010) found that social support predicted perceived quality of life independent of quality of the paid worker and family roles. Further, spouse support appeared to have twice as large an effect on quality of life as did social support at work. Grzywacz and Marks (2000b) found that a number of social support variables were associated with positive and negative spillover for women. Greater family criticism, greater spousal disagreement, and less social support at work were associated with greater negative work-to-family spillover. Also, low support at work was associated with low positive work-to-family spillover. Higher spousal disagreement and family criticism were associated with greater negative work-to-family spillover, and higher spousal, family, and work support were all associated with greater positive spillover from family to work. Finally, low spousal support and high spousal/family criticism were associated with greater negative family-to-work spillover.

Grzywacz and Marks reported similar results for men regarding negative family-to-work spillover, but noted that the relationship was noticeably more robust for women compared to men, although the gender difference was not statistically significant. Roxburgh (1999) however, uncovered notable gender differences in the influence of social support on job satisfaction in a representative sample of Canadian men and women in the dual roles of spouse and paid worker. For men, high coworker support increased job satisfaction regardless of their levels of perceived partner support, and perceived partner support had no impact on men's job satisfaction either alone or at any level of partner support. For women, coworker support only increased job satisfaction when they also had high levels of perceived partner support. Overall, these studies demonstrate the importance of social support both in and out of the home environment, but also suggest that support from the home environment appears to be relatively more important than social support at work among women, and that social support from the home environment may be more important to women compared to men.

MASTERY/SELF-ESTEEM

The extant research on the influence of mastery and self-esteem in the context of multiple role occupancy is somewhat limited by the fact that, rather than examining each construct in its own right, mastery and self-esteem have often been collapsed to create a summary index representing both constructs. Nevertheless, research indicates that mastery/self-esteem relate to role-related variables and impact mental health. For example, Martire and colleagues (Martire, Stephens, & Franks, 1997) prospectively examined the relationship between feelings of role-specific self-esteem/mastery at the first time-point and interpersonal and psychological outcomes at a follow-up time-point two months later in a sample of 72 women who held the roles of caregiver, spouse, and parent. Regarding the interpersonal outcomes, mastery/self-esteem in the role of caregiver at the

first time-point predicted marital satisfaction and family cohesion, and mastery/self-esteem in the spouse role predicted family cohesion. Regarding the psychological outcomes, mastery/self-esteem in the mother role predicted negative affect. Further, in all instances mastery/self-esteem predicted the outcomes at the two-month follow-up above and beyond the effect of mastery/self-esteem at the first time-point. Schwartzberg and Dytell (1996) demonstrated that role stress was significantly related to self-esteem among women from dual-earner families. Schwartzberg and Dytell further examined the effect of role stress on depression among these women but unfortunately did not directly examine self-esteem as a potential mediator of the role stress–depression relationship.

Using the slightly larger baseline sample from the Martire et al. (1997) study, Franks and Stephens (1992) conducted mediational analyses testing the hypothesis that role stress leads to poor well-being by decreasing role-specific mastery/self-esteem. Using a causal steps approach (Baron & Kenny, 1986), they found that role-specific feelings of mastery/self-esteem partially mediated the effect of role stress on both positive and negative affect for all three roles that were examined in the study (caregiver to an adult family member, mother, and spouse).

Adelmann (1994) also examined the effect of multiple role occupation on self-efficacy and found a significant and positive relationship between number of social roles occupied and self-efficacy above and beyond health problems, gender, race, age, and education. Christensen, Stephens, and Townsend (1998) examined how mastery in a role influences life satisfaction in a sample of female adult caregivers who also held three other social roles (employee, mother, and spouse, for a total of four roles examined). Life satisfaction was affected by mastery in three of the four social roles examined (parent care, mother, wife). Further, the effect of role-specific mastery for each role was significant above and beyond the influence of role-specific mastery in all other roles. Additionally, Christensen et al. found that life satisfaction increased with the number of roles in which one reported high mastery. Thus, it is likely that feelings of mastery in each role contribute uniquely to life satisfaction, as well as have an additive effect on life satisfaction. Findings suggest that multiple roles may be beneficial to well-being through having many opportunities to experience mastery.

SUMMARY

We have presented evidence that it is becoming more and more common for women to occupy multiple roles. Further, trends in many of these roles (e.g., worker, caregiver) suggest that the multiple role phenomenon will only increase in the future. Research and theory in this area stress that occupation of multiple social roles impacts mental health through two types of mechanisms: the experiences within a role, including consequences inherent in occupying multiple roles, and inter- and intrapersonal risk and protective factors of mental health outcomes. Extant research, however, appears to have focused primarily on role-related

variables, and research on inter-/intrapersonal variables is lacking in comparison. Nevertheless, extant research clearly demonstrates the importance of these two types of determinants of mental health among women juggling multiple roles.

There are some specific areas that could particularly benefit from further research. For example, limited research indicates that women and African Americans occupy fewer social roles on average. Given the demonstrated benefit of multiple roles on mental health, it would be beneficial to have more research that corroborates this finding and illuminates mechanisms of this disparity that can be targeted for intervention. More generally, increased research on multiple roles among minority and other understudied populations is needed. As another example, research has demonstrated that time spent in roles has both positive and negative mental health effects, and research is needed to understand what variables affect these different trajectories. More research is broadly needed that seeks to understand the role of inter-/intrapersonal variables on mental health among women occupying multiple roles, especially empirical examination of additional variables (beyond social support and mastery) that are hypothesized to play a role (e.g., self-efficacy, belonging, connectedness). Furthermore, the proposed mediating role of inter-/intrapersonal variables on the relationship between multiple role occupancy and mental health, or more importantly, the relationship between role-related experiences and mental health, merits further research. Finally, increased research within a longitudinal framework is encouraged in order to gain a fuller understanding of the causal pathways between multiple role occupation and mental health. In sum, it is essential to understand the ways in which multiple roles exert both positive and negative influences on women's well-being. Illuminating mechanisms by which multiple roles impact mental health is particularly important, in that an understanding of these processes can serve to inform work and social policies aimed toward maximizing mental health in women.

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Chapter 4

Women with Disabilities

Mental Health Impact of Disabilities and Ableism

Michele A. Paludi

Because women with disabilities are marginalized by society for being disabled and for being women and if we advocate for ourselves we're called complainers and/or bitchy and/or negative and/or confrontational, and if we don't we get walked upon like doormats ... and if we use wheelchairs we are looked upon with condescending pity, and if we don't use wheelchairs it is assumed we aren't disabled and if we use wheelchairs but still have some mobility it is assumed we don't really need them in the first place ... and because many of us take medications daily which will have effects on us we will never know about because no research has been done on how these medications affect women's bodies, since it is thought that protecting our reproductive organs is always our biggest concern in life and a reason to keep women out of medical studies even though the male-dominated medical industry never bothered to ask our opinions about that ... and for lots and lots of other reasons, we are feminists with disabilities fighting for our rights.

Jen Robinson

Many girls and women formulate ideas about their roles in North American culture from media content and report feeling inadequate when they compare themselves with media portrayals of femininity (Paludi, 2010a). They feel dissatisfied with their physique, teeth, hair, weight, breast size and height (Jackson, 1992; Kilbourne, 1999). Children Now (1997) reported that 31% of adolescent girls in their research altered their appearance to look more like a television character. In addition, there is a “double standard of aging” in North American culture (Sontag, 1979). Consequently, middle-aged and older women are more dissatisfied with age-related physical changes than are middle-aged and older men. Often, older women strive to achieve the facial features and physique of younger women through age-concealment techniques in order to be “accepted” by a culture that values young, attractive women (Chrisler, Gorman, Chapman, & Serra, 2010; Digman & Otte, 2010; Frederick, Peplau & Lever, 2008; Paludi, 2010a).

Furthermore, adolescent and adult women are on a never-ending cycle of dieting, visiting fitness centers more than once a day, and working to achieve a “fashion model” look: tall, blond, middle- to upper-class, White, and bordering on emaciation (Kempa & Thomas, 2000; Striegel-Moore & Smolak, 2000). Actress Heidi Montag’s recent 10 plastic surgery procedures highlight just how far a woman is likely to go in order to meet the standard of beauty in North American culture. She once quipped:

I was made fun of when I was younger, and so I had insecurities, especially after I moved to L.A. People said I had a “Jay Leno chin”; they’d circle it on blogs and say nasty things. It bothered me. And when I watched myself on *The Hills*, my ears would be sticking out like Dumbo! I just wanted to feel more confident and look in the mirror and be like, “Whoa! That’s me!” I was an ugly duckling before. (Garcia, 2010)

Montag had the following surgeries: mini brow lift; Botox in forehead and frown area; nose job revision; fat injections in cheeks, lips and nasolabial folds; chin reduction; neck liposuction; ears pinned back; breast augmentation revision; liposuction on waist, hips, and inner and outer thighs; and buttock augmentation. She stated, “We all want to feel attractive ... so who is anyone to judge me?” (Garcia, 2010).

WOMEN WITH DISABILITIES: HIDDEN FROM VIEW

This image of attractiveness and perfection is one in which women with physical and mental disabilities are excluded. Even a cursory glance at magazines such as *Cosmopolitan*, *Vogue*, *More*, *Glamour* and *Marie Claire*, as well as Hollywood movies and television shows, reveals a lack of representation of women with disabilities. This means that the lives of women with disabilities remain hidden from able-bodied individuals (Banks, 2010a; Schriempf, 2001). Furthermore, when women with disabilities are portrayed in the media, they are done so in stereotypic ways and

frequently met with jokes based on their perceived lack of attractiveness and inability to have a significant social and intimate relationship with someone (Keller, Galgay, & Ryan, 2010). In addition, most of the women portraying disabled individuals in the media are able-bodied actors who commonly exaggerate the ways in which women with disabilities behave in relationships, in school, or at work.

In this chapter I discuss stereotyping of women with disabilities in more detail, including the relationship among stereotypes, prejudice, and discriminatory treatment of women with disabilities. I will also discuss the impact of disabilities, discrimination, and violence against women with disabilities on their mental health. Throughout this chapter I use the term “women with disabilities” rather than “disabled women” to highlight that these women are more than their disability and to counter stereotypic discussions of women with disabilities (Paludi, DeSouza, & Dodd, 2010). This terminology is in keeping with the American Psychological Association’s guidelines to reduce bias in language (1992) and the disability rights movement (Green, Davis, Karshmer, Marsh, & Straight, 2005).

INCIDENCE OF WOMEN WITH DISABILITIES GLOBALLY

There’s a kind of sick security some people get out of keeping away from people with disabilities. They are running away from any situation that’s not totally pure and all-American and that requires them to do any thinking.

Major Owens

The Americans with Disabilities Act (ADA; Equal Employment Opportunity Commission, 2002) defined “disability” in the following manner: “An individual with a disability is a person who:

- Has a physical or mental impairment that substantially limits one or more major life activities;
- Has a record of having such an impairment; or
- Is regarded as having such an impairment.”

Some women are born with a disability; others get ill or have an accident that results in them having a disability. Still other women develop a disability as they age (Sabolsi, Solomon, & Manson, 2001). Men have higher rates of disability throughout childhood, adolescence, and early adulthood. However, women have higher rates of disabilities in middle and later adulthood, partly as a consequence of their longer life expectancy (U.S. Census Bureau, 2000). Furthermore, women have higher rates of severe disabilities than men. African American women have the highest rate of severe disability (U.S. Census Bureau, 2000).

Individuals with disabilities represent the largest minority group in the United States (Mertens, Wilson, & Mouny, 2007). The American Community Survey (Erickson, Lee & von Schrader, 2010) reported that in the United States, 12.4%

of noninstitutionalized women, taking into account all races, national origins, education levels, and ages, have a disability. This percentage translates into 18,986,900 women. The American Community Survey also provided percentages of women of color who reported a disability. Their findings resulted in the following: African American: 14.5%; Asian: 7.3%; Native American/Alaskan Native: 16.9%; White: 12.6%; and Other: 9.2%.

According to the World Bank (2010), women with disabilities comprise 10% of all women globally. In addition, women with disabilities make up 75% of all disabled individuals in low- and middle-income countries. Furthermore, women are likely to become disabled as a consequence of poorer working conditions, gender-based violence, poverty, and poor access to quality health care (Emmett & Alant, 2006). As a consequence of gender-based violence and lack of access to reproductive health care, women with disabilities have difficulty in preventing HIV infection. The unemployment rate for women with disabilities in developing countries is 100% (DAWN Ontario, 2010).

Girls and women with disabilities have a higher mortality rate than do men with disabilities (DAWN Ontario, 2010). The United Nations Development Program noted that in most developing countries, families respond to boys and men who are sick or have disabilities differently than they do to girls and women: males are taken to medical and health services more than females. According to DAWN Ontario (2010):

[W]hen combined with traditional practices of males being fed before females, and female children receiving what is left over, the result is that often the disabled female child becomes malnourished as well. In countries where “son preference” is culturally dominant, girls, and especially girls with disabilities, are particularly endangered. (p. 2)

Disabilities in women include¹ chronic health problems (e.g., autoimmune disorders, such as diabetes, lupus, cardiac disease, chronic fatigue syndrome, and HIV/AIDS), psychiatric disorders (see volume 3 of this book set), traumatic brain injury, learning disabilities, situational disabilities (e.g., morning sickness during pregnancy, migraines), visual disabilities, hearing disabilities, and invisible disabilities. Each of these disabilities is accompanied by complications for women.

For example, approximately 10 million women aged 20 years or older have diabetes (Centers for Disease Control and Prevention, 2005). Type I diabetes develops when the pancreas stops making insulin. Type II diabetes occurs when the cells of the body cannot use insulin the right way or when the pancreas cannot make a sufficient amount of insulin. Older women and women of color are disproportionately represented among diabetics. The prevalence of diabetes is approximately two to four times higher in African American, Asian/Pacific Islander, Latina, and American Indian women than in White women. The risk for death among women with diabetes is approximately twice that of women without diabetes of the same age. Complications of diabetes include heart disease, stroke, high blood pressure, blindness, kidney disease, nervous system disease, amputations, and dental disease (Thompson-Reid, McGuire & Beckles, 2001).

In addition, women with diabetes are more susceptible to other illnesses and, if acquired, have worse prognoses. As an example, when a diabetic woman contracts pneumonia, she is more likely to die than a woman who is not diabetic (Centers for Disease Control and Prevention, 2005). Diabetes is a major cause of death among middle-aged women (Sabolsi, Solomon, & Manson, 2001).

Systemic lupus erythematosus (SLE) is a chronic, autoimmune disease in which an individual's immune system attacks healthy tissues. Nine out of ten individuals who are diagnosed with SLE are women. Symptoms of SLE include a "butterfly" rash on the nose and cheek; erratic blood-cell count; kidney damage; neurological symptoms; presence of antinuclear antibodies; presence of immunological disorders; photosensitivity; serositis; a small, coin-shaped, red, flaky rash anywhere on the body; and swelling and/or pain of the joints and ulcers inside the mouth. According to the American College of Rheumatology, an SLE diagnosis requires a minimum of four of the above listed symptoms to occur together at the same time (Browning, 2006).

African American women are three times more likely to be diagnosed with SLE than are White women. In addition, SLE is common in Latina, Asian, and Native American women. Complications for women with SLE include heart disease and osteoporosis (Lupus Foundation of America, 2010). Women with SLE have to endure flare-ups when symptoms become more pronounced and/or when they have new symptoms (e.g., pain, stomachache, severe headache, or fever).

Heart disease is a third type of disability common in women. Historically heart disease has been considered to be more prevalent in men than in women. However, similar to men, heart disease is the leading cause of death for women in the United States (Centers for Disease Control, 2005; Travis & Meltzer, 2008). Ischemic heart disease is the leading cause of women's deaths (Bell & Nappi, 2000). In addition, women are more likely to die from heart disease than are men (Travis & Meltzer, 2008).

Lloyd-Jones, Adams, and Brown (2010) indicated that approximately 7% of White women, 9% of African American women, and 7% of Latinas are living with heart disease. Certain medical conditions and lifestyle choices (e.g., high cholesterol, high blood pressure, diabetes, cigarette smoking, obesity, poor diet, physical inactivity) place women at a higher risk for heart disease (Heron, 2007). Women's risk for heart disease increases with age; the loss of natural estrogen that accompanies menopause is considered to contribute to higher risks of heart disease in women.

WOMEN WITH DISABILITIES AS "THE OTHERS": ABLEISM, DISCRIMINATION, AND HARASSMENT

Women would be disproportionately affected by the privatization of social security. It is one of the most important safety nets for American women in old age, or in times of disability, to insure financial income for their families.

Barbara Mikulski

Campbell (2001) noted that women with disabilities, including diabetes, lupus, and cardiac disease, endure ableism, a type of discrimination which is defined as:

A network of beliefs, processes and practices that produces a particular kind of self and body (the corporeal standard) that is projected as the perfect, species-typical and therefore essential and fully human. Disability is cast as a diminished state of being human. (p. 44)

There is thus an intersectionality between gender and disability: women experience harassment and discrimination more than do men in general (Emmett & Alant, 2006; Habib, 1995; Paludi, Paludi, & DeSouza, 2010). However, women with disabilities face compound discrimination or a double jeopardy by being both female and disabled (Banks, 2010b; Ewing, 2002; Schur, 2003). According to Wendell (2009), the “disabled are made ‘the other’ who symbolize failure of control and the threat of pain, limitation, dependency and death” (p. 1527). For women of color, this intersectionality is even more pronounced and includes racism and sexism.

Healey (1994) noted that there is a common agenda among women, women with disabilities, and older women: “The stereotype is that all old women are disabled and all women with disabilities may as well be old; both groups are stigmatized and marginalized” (p. 65). In addition, there is the shared social invisibility and oppression (Banks, 2010a).

AMERICANS WITH DISABILITIES ACT: LEGISLATION ALONE IS NOT SUFFICIENT

If we are to achieve a richer culture ... we must weave one in which each diverse human gift will find a fitting place.

Margaret Mead

The Americans with Disabilities Act (ADA) was signed into law in 1990. The ADA was implemented on July 26, 1992. The ADA is a civil rights law that consists of five titles. These titles are identified as follows:

Title I prohibits employment discrimination against qualified individuals with disabilities

Title II prohibits discrimination in public services

Title III prohibits discrimination in public accommodations

Title IV prohibits telecommunications discrimination

Title V provides instructions to federal agencies involved in regulating and enforcing Titles I–IV.

On September 25, 2008, President George W. Bush signed the Americans with Disabilities Act Amendments Act of 2008. This act became effective January 1, 2009, adding significant changes to the definition of “disability”

(Equal Employment Opportunity Commission, 2008). For example, this act expands the definition of “major life activities” by including the following that had not been identified by the Equal Opportunity Commission (EEOC): bending, communicating, and reading. In addition, the act includes major bodily functions, such as “functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine and reproductive functions.” Furthermore, the act indicates that an impairment that is in remission or is episodic would still be considered a disability if the impairment would substantially limit the individual’s major life activity when active.

Despite the legislation concerning disability discrimination that has existed in the United States since 1992, women (and also men) with disabilities still face enormous discrimination and harassment in education, employment, and access to housing and health care (American Community Survey, 2003; Mertens, Wilson, & Mounty, 2007; Paludi, DeSouza & Dodd, 2010; Vande Kemp, Chen, Erickson, & Friesen, 2003). For example, *Discrimination Against Persons with Disabilities: Barriers at Every Step* (Turner, Herbig, Kaye, Fenderson, & Levy, 2005) reported discriminatory treatment toward individuals with disabilities, including by landlords who refused to speak to individuals who were hearing impaired while giving people with no disabilities information about available apartments.

In addition, employers are reluctant to hire individuals with disabilities because of concerns related to increased cost; safety issues; legal liability; reactions of coworkers, vendors, clients, and other employers; and the need for increased supervision of employees with disabilities (Paludi, DeSouza, & Dodd, 2010). Women who have disabilities are less likely to be employed than women without disabilities or men with or without disabilities. In addition, women with disabilities earn less than men with disabilities, and the wage gap increases with time (Doren & Benz, 2001). Women with disabilities are also likely to be employed in positions rated as having lower status and as part-time employees than men are with disabilities. Finally, women with disabilities do not remain at any one job as long as do men with disabilities. As noted by Paludi, DeSouza, and Dodd (2010), stereotypes get expressed behaviorally in discriminatory treatment of women employees, especially women of color, with disabilities in terms of their wages, pay increases, and promotions.

In addition, women employees with disabilities experience hostile work environments because of their sex and disability (Holzbauer & Berven, 1996; Johnson, 2008; Schroeder, 2009; Susser, 2005). According to the EEOC (2004):

The ADA prohibits offensive conduct that is sufficiently severe or pervasive to create a hostile or abusive work environment. Acts of harassment may include verbal abuse, such as name-calling, behavior such as graphic and written statements, or conduct that is physically threatening, harmful, or humiliating. ... To be actionable, conduct related to an employee’s intellectual disability must be sufficiently severe or pervasive as to be both subjectively hostile and abusive (to the person) and to a reasonable person.

Thus, legally, a hostile work environment may exist with respect to an individual's disability when:

- The employee is a qualified individual with a disability.
- Verbal and/or nonverbal behavior occurs because of an individual being a member of a protected class (e.g., having a physical or mental disability).
- The harassment is unwanted or unwelcome.
- The harassment is severe or pervasive enough to unreasonably impact the employee's work environment.
- The employer knew or should have known of the harassment and failed to take prompt and remedial action.

Behaviorally, a hostile work environment for disability can include posters, emails, cartoons, or pictures displayed in the work area that create an offensive and intimidating environment for employees with disabilities; engaging in threatening, intimidating, or hostile acts toward an employee with a disability; actual denial of a job-related benefit to an employee with a disability; telling jokes pertaining to people with disabilities; suggestive, obscene, or insulting sounds about individuals with disabilities; or mimicking an employee with a speech, visual, or hearing impediment.

In addition, a hostile work environment for employees with disabilities includes inappropriate reference to disability, unwelcome discussion of the impact of disability, and a refusal to work with or an exclusion of people with disabilities from social events or staff meetings and training programs.

The following cases illustrate disability harassment.

Flowers v. Southern Regional Physician Services, Inc. (2001)

Sandra Flowers was employed by Southern Regional Physician Services for two years and by its predecessor for four years prior. Ms. Flowers was a medical assistant to a physician. Their relationship at work was friendly. However, when her supervisor learned that Ms. Flowers was HIV-positive, he refused to shake her hand, intercepted her telephone calls, eavesdropped on her conversations, and hovered around her desk. In addition, the supervisor submitted Ms. Flowers to four random drug tests within a one-week period.

While her performance appraisals had been good prior to her supervisor learning of her health status, she was written up twice and put on a 90-day probation. A few days prior to the probation ending, the supervisor wrote up Ms. Flowers and put her on another 90-day probation. The president of the company referred to Ms. Flowers as a "bitch" and that he was "tired of her crap." Ms. Flowers was subsequently terminated.

Based upon this evidence, a jury determined that Ms. Flowers had been subjected to disability harassment. The appeals court affirmed this lower court's decision and indicated that the ADA is intended to protect employees against

harassment because of their being a member of a protected category, in this case an employee with a disability (Paludi, DeSouza, & Dodd, 2010).

EEOC v. Smith Personnel Solutions (2010)

Jacquelyn Moncada is hearing impaired. She applied for a position as a stock clerk with a staffing company, Smith Personnel Solutions. Smith refused to consider Ms. Moncada for the position because of her deafness. Her job application was not accepted nor was she interviewed. Rather, Smith told Ms. Moncada's sign language interpreter that there was no position open for her.

In addition, Smith informed Ms. Moncada that she could be "dangerous" because she "couldn't communicate." Smith ignored the fact that Ms. Moncada had worked for approximately three years as a stock clerk and never experienced difficulties with communication because of her having a disability.

According to the EEOC trial attorney Joel Clark: "Jacquelyn wasn't asking for special treatment, just the chance to apply for a job." Heather Bise, a deafness resource specialist for the Deaf Action Center, provided expert witness testimony for the EEOC at trial. She stated: "I believe this case will have a holistic affect on the deaf community, and the walls of audism—an attitudinal barrier towards people with hearing loss—will eventually fade. Deaf individuals are simply asking for a chance, and I don't think we are asking for much" (Equal Employment Opportunity Commission, 2010, p. 2). The jury awarded Ms. Moncada \$184,400 after finding disability discrimination by Smith.

A CONTINUUM OF DISCRIMINATION

In the fiscal year 2009, the EEOC received 21,451 charges of disability discrimination. Charges included discriminatory treatment at work because of orthopedic and structural impairments of the back, nonparalytic orthopedic impairment, cancer, cumulative trauma disorder, kidney impairment, diabetes, alcoholism, Alzheimer's, anxiety disorder, tuberculosis, depression, manic depressive disorder, and allergies.

Psychological disability charges filed with the EEOC make up approximately 30% of disability discrimination charges filed each year (Paludi, DeSouza, & Dodd, 2010).

Incidents of ableism are precipitated by aggressive verbal and nonverbal behavior that is unnoticed and/or unreported by witnesses to the behavior. In recent years, research has documented a relationship among incivility and harassment/discrimination. Incivility has been defined as discourteous or rude behavior that violates norms for respect for individuals (Andersson & Pearson, 1999). Incivility includes (a) verbal aggression toward a woman with a disability; (b) isolation of a woman with a disability; and (c) disrespect, including public humiliation (Andersson & Pearson, 1999; Cortina, Magley, Williams, & Langout, 2001).

Disability microaggressions are subtle verbal, behavioral, or environmental insults that target women with disabilities (Nadal, Hamit, & Issa, 2010). Microinsults include verbal and nonverbal behavior that conveys rudeness and

demeans a group, such as women with disabilities (Sue, Bucciari, Lin, Nadal, & Torino, 2007). Microinvalidations are actions that negate or exclude the psychological thoughts or feelings of individuals who represent different groups, including women with disabilities (Sue, Bucciari, Lin, Nadal, & Torino, 2007). Disability microaggressions are often discounted because they are ambiguous, and individuals who engage in this form of discrimination argue that the slights are unintentional. However, disability microaggressions result in significant impact for women with disabilities (Keller, Galgay, & Ryan, 2010). Ignoring or tolerating lower-level abuse creates an environment conducive to more serious aggressive behavior, including discrimination/harassment. Thus, when verbal aggression, isolation, and disrespect of individuals are tolerated or go unnoticed by supervisors, teachers, or other administrators, discrimination and harassment will follow (Paludi, 2010b).

VIOLENCE AND VICTIMIZATION OF WOMEN WITH DISABILITIES

After my child was born, my husband became jealous and didn't want me to get up and take care of her. He would take my chair away from me and tied me up when I pulled myself out of bed. I left him the first chance I had.

49-year-old woman with spinal cord injury since age 17

(Nosek, 2010)

Furthermore, women with disabilities suffer individual forms of violence as well as societal violence (Barranti & Yuen, 2008; Cramer, Gilson, & Depoy, 2004; Paludi & DeFour, 2010; Hassouneh-Phillips, McNeff, Powers, & Curry, 2005). Individual forms of violence include intimate partner abuse and sexual assault that causes physical and/or psychological harm or humiliation and perpetuates women's subordination (Barranti & Yuen, 2008; Heise, Pitanguy, & Germain, 1994). Societal violence against women with disabilities includes impaired access to employment or education, workplace discrimination, and harassment. This type of violence affects women as a class (Hassouneh-Phillips, McNeff, Powers, & Curry, 2005; Heise, Pitanguy, & Germain, 1994).

Incidence rates of violence against women with disabilities are startling, including disability-related emotional abuse, disability-related physical abuse, financial abuse of individuals with disabilities, and caretakers' abuse of individuals with disabilities (Banks, 2010b; Nixon, 2009; Olsvik, 2006). For example, 1.5 million women living in institutions are victims of abuse annually. Of the alleged perpetrators of violence against women with disabilities, 33% are adult children, 22% other family members, 16% strangers, and 11% spouses/partners.

Nosek, Hughes, Taylor, and Howland (2004) and Banks (2010a) noted that the most common form of disability-related sexual abuse is spousal rape. According to Mertens, Wilson, and Mounty (2007):

Individuals who are blind and those with other disabilities are more likely to be abused because they may be perceived as less human, less adult, less capable, as not having equal needs or rights, or as less likely to be believed if they report the abuse. (p. 596)

PSYCHOLOGICAL EXPLANATIONS FOR DISCRIMINATION, HARASSMENT, AND VIOLENCE AGAINST WOMEN WITH DISABILITIES

Being disabled should not mean being disqualified from having access to every aspect of life.

Emma Thompson

Disability Stereotyping

Much of the discrimination and abuse of women with disabilities is related to stereotyping and stigma (Green, Davis, Karshmer, Marsh, & Straight, 2005; Paludi, DeSouza, & Dodd, 2010; Van Brakel, 2006). Stereotypes refer to individuals' thoughts/cognitions that typically do not correspond with reality. Stereotypes occur when individuals are classified by others as having something in common because they are members of a particular group or category of people (e.g., individuals with physical disabilities, individual employees with mental disabilities). Psychological research has identified that stereotypes have the following characteristics (Fiske & Stevens, 1993):

1. Groups that are targeted for stereotypes are easily identified and relatively powerless.
2. There is little agreement between the composite picture of the group and the actual characteristics of that group.
3. This misperception is difficult to modify even though individuals who hold stereotypes have interacted with individuals of the group who disconfirm the stereotypes.
4. This misperception is the product of a bias in individuals' information-processing mechanisms.

Disability stereotyping is a psychological process that describes individuals' structured sets of beliefs about the personal attributes of people with disabilities (e.g., incompetent, asexual, incapable of participating fully in all aspects of life, victims, nonsexual, or having an illness that can be contracted by contact) (Fine & Asch, 1998; Goodman-Delahunty, 2000; Lasalvia & Tansella, 2008). Psychologists have identified an emotional component to stereotypic cognitions: prejudice as well as a behavioral component to individuals' cognitions (i.e., discrimination). Thus, individuals' statements and nonverbal gestures toward individuals with disabilities

provide insight into their structured set of beliefs and emotions about people with disabilities (Bruyere, Erickson, & Ferrentino, 2003).

Stigma is the application of a negative trait to a group or individual (Scheid, 2005). Women with disabilities, especially mental disabilities, are twice stigmatized by the labels of disability and mental illness, and they are widely perceived as dangerous, irrational, slow, stupid, and unpredictable.

Hate Crimes against Women with Disabilities

Much violence against women with disabilities occurs in the form of hate crimes (Sorensen, 2010). A hate crime is a crime which in whole or part is motivated by the offender's bias toward the victim's status. Hate crimes are intended to hurt and intimidate individuals because they are perceived to be different with respect to their sex, religion, race, color, national origin, sexual orientation, gender, or disability (Paludi, DeSouza, & Dodd, 2010; Paludi, Ellens, & Paludi, 2010). While hate crimes are assaults against an individual, they are also assaults against everyone who shares the victim's status (e.g., women, individuals with disabilities).

Legislation lists specific crimes that are identifiable as hate crimes, including murder, manslaughter, robbery, aggravated assault, burglary, motor vehicle theft, arson, forced and nonforced sex offenses, intimidation, destruction, damage or vandalism of property, and other crimes involving injury to any person or property in which the victim is intentionally selected because of the actual or perceived religion, race, sex, sexual orientation, ethnicity, or disability of the victim.

When the behavior does not fall into one of the listed criminal categories identified above, hate offenses are referred to as bias-motivated incidents. These incidents may include cases of verbal slurs and be precursors to more serious hate crimes (Paludi, 2010b; Paludi, Ellens, & Paludi, 2010). Thus, violence against women with disabilities exists along a continuum, from incivility and microaggressions to hate crimes, including assault and murder (Paludi, 2010b).

According to Sorensen (2010), individuals who commit hate crimes against women with disabilities:

often feel empowered to murder, rape or assault ... because of their hatred and contempt and because they believe that many in our society share that bias and contempt and are less likely to be outraged or to even report the crimes committed. (p. 2)

Sorensen (2010) noted that approximately 31% of personal crime committed in California is committed against an individual with a disability and that less than 5% of hate crimes against individuals with disabilities are reported in California. This is in sharp contrast with more than 42% of crimes against individuals with no disabilities.

IMPACT OF DISABILITIES AND ABLEISM ON WOMEN'S MENTAL HEALTH AND WELL-BEING

Congress acknowledged that society's accumulated myths and fears about disability and disease are just as handicapping as the physical limitations that flow from actual impairment.

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Although disabilities, including mental disorders, reside within individuals, disability is socially constructed from biological reality (Wendell, 2009); that is, how society views people with disabilities significantly affects their well-being (e.g., Mason, Pratt, Patel, Greydanus, & Yahya, 2004).

Women with disabilities experience mental health effects both from the disabilities themselves and from ableism as a consequence of their perceived or actual disability. For example, women with disabilities become depressed as a consequence of having to deal with the symptoms and changes brought on by the disability (i.e., situational depression). In some disabilities, such as multiple sclerosis, depression is a consequence of the brain's demyelination process.

Cook (2003) and Gurland, Wilder, and Berkman (1988) identified co-occurrences of disability and depression in women. Depression is commonly experienced by women with diabetes (Ali, Stone, Skinner, Robertson, Davies & Khunti, 2010), cardiovascular disease (McFarlane, Symes, Frazier, McGlory, Henderson-Everhardus, Watson, & Liu, 2010), and lupus (Petri, 2010). Depression impairs women's health-related quality of life.

Research on ableism and violence has a documented impact on several areas of functioning, including emotional/psychological, physiological or health related, career/work, social, and self-perception (Bahm & Forchuk, 2008; Banks & Ackerman, 2003; Green, Davis, Karshmer, Marsh, & Straight, 2005; Holzbauer & Berven, 1996; Stefan, 2002). Most individuals experience severe distress associated with ableism and violence. The symptoms become exacerbated when in continued contact with the perpetrator and when being retaliated against for complaining about disability discrimination or harassment to one's employer, school administrator, or housing director.

Emotional/psychological responses by women to both ableism and violence include withdrawal from social settings, depression, fear, anger, isolation, fear of crime in general, helplessness, shock, and decreased self-esteem. Post-traumatic stress disorder (PTSD) is a consequence of ableism. Symptoms of PTSD include anxiety, physiological arousal, irritability, avoidance/denial, intrusion, repetitive nightmares, impaired concentration and memory, and acting-out behaviors. Immediately after the violent episode, women experience a sense of disbelief, shock, and psychological and physical numbing. In the few days following the incident, individuals experience three different types of consequences:

- a. Reexperiencing consequences (e.g., dreaming, flashbacks)